Services to Elderly Residents with Mental Health Problems in Long-Term Care Facilities

Guidelines

Canada

REPORT OF THE SUBCOMMITTEE ON INSTITUTIONAL PROGRAM GUIDELINES

Guidelines for Establishing Standards for:

SERVICES TO ELDERLY RESIDENTS WITH MENTAL HEALTH PROBLEMS IN LONG-TERM CARE FACILITIES

Published by
Health Services and Promotion Branch
Health and Welfare Canada

Également disponible en français sous le titre
Services dispensés aux personnes âgées atteintes de troubles mentaux dans les établissements de soins prolongés

90-06654/

NOTE

The information contained in these guidelines is considered current as of the date of approval; however, since health care and health technology are constantly changing fields, any suggested amendments would be welcomed. Information on new developments or related issues should be directed to:

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Further copies of these guidelines, in English and in French, can be obtained from the above address.

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Cat. No. H39-49/5-1990E
ISBN 0-662-17623-5

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PREFACE

Technological advancements and changes in the delivery of health care services have led to the need for guidelines to assist in planning and implementing health programs and services in institutions and the community. The guidelines[1] that follow represent one of a series of publications produced under the direction of the Subcommittee on Institutional Program Guidelines. They provide a consistent definition of requirements for a number of special care units, services and programs in health institutions and the community.

In general, guidelines are based on information, knowledge, experience, research and expert opinion from health professionals and organizations throughout Canada. Additional material is often obtained from national and international health organizations and from other experts knowledgeable in the subject. In this way, many Canadians from across the country can contribute to the guidelines, and a consensus on the suggested approach can be achieved.

BACKGROUND

Under the direction of the Federal/Provincial/Territorial Advisory Committee on Institutional and Medical Services, the guidelines program has been in operation since 1972. A standing subcommittee of the Advisory Committee, the Subcommittee on Institutional Program Guidelines, composed of federal and provincial government and professional representatives, coordinates the development of the guidelines commissioned by the Advisory Committee.

The guidelines are produced by expert working groups of health professionals, some of whom are government representatives. The final draft is reviewed and recommended by the Subcommittee, for approval by the Advisory Committee.

1 A complete list of Institutional Program Guidelines appears in Appendix A.

PURPOSE

The purpose of the guidelines is to provide a comprehensive definition of requirements for health services. While a consensus of expert knowledge and experience is reflected in the guidelines, such guidelines should not be regarded as rigid standards. Provincial health authorities may modify the application of guidelines to meet their needs.

Where development of a service is being contemplated, the guidelines may help in determining the need for such a service either locally or regionally, or in some cases provincially or interprovincially.

Established services may take advantage of the guidelines to screen deficiencies and solve problems without having to develop new services. Where a service already exists, the guidelines will help to:

- identify problems related to administration, personnel, equipment and facilities,
- determine necessary remedial action, and
- set priorities for corrective measures on the basis of clinical need, funding and the degree to which the service is deficient.

FUTURE

The dramatic increase in the number of intensive and special care services in health institutions has given rise to the need for additional facilities, specialized equipment and highly trained personnel. At the same time, new approaches to patient care have evolved in a manner that emphasizes the need for a continuum of care in which admission to an institution is only one aspect of total care. Therefore, linkages along the health care continuum, ranging from illness prevention to chronic care, must be identified. As new treatments and procedures are put into practice, there will be a continuing need for guidelines to assist those involved in the planning and operation of services.

REVISIONS

Due to the rapidly changing nature of health care delivery, guidelines will need updating and revision. The Subcommittee on Institutional Program Guidelines plans and oversees these revisions.

ACKNOWLEDGEMENTS

The Subcommittee acknowledges, with sincere appreciation, the immense amount of work undertaken and time given by practising Canadian health professionals in providing detailed written information and guidance throughout the preparation of these guidelines. In addition, acknowledgements are due to the many others who in any way contributed advice and information to this endeavour.

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CHAPTER 1
INTRODUCTION

1. INTENDED READERSHIP

These guidelines have been developed primarily for the benefit of planners, administrators and board members of systems or facilities which provide long-term residential care to elderly people. Virtually all long-term care facilities serve significant numbers of people with mental health problems, although for many residents a physical health problem may have been the primary reason for admission.

2. TARGET POPULATION

"Elderly people with mental health problems"[2] is used here as a general term describing people aged 65 years and over who have emotional, behavioural or cognitive problems (psychiatric) which interfere with their ability to function independently, which seriously affect their feelings of well-being, or which adversely affect their relationships with others. The group includes persons with a range of different conditions, such as dementia, depression, "disturbing behaviours," anxiety, personality disorders, psychoses and adjustment difficulties. These conditions can result in

2 Terminology: Opinions concerning acceptable terminology vary widely across regions, settings and disciplines. The authors have chosen to use the adjective "elderly" when referring to chronologically advanced age; they acknowledge that the cut-off point of 65 is of historical/administrative rather than biological significance, and that persons aged 65 and over are far from homogeneous in their needs, abilities, preferences and health status.

The authors have also chosen to use the expression "resident with a mental health problem" as an overall term for a heterogeneous target population experiencing a wide variety of cognitive or behavioral dysfunctions and emotional disturbances. This somewhat unconventional choice was made for two main reasons: first, to avoid language considered more stigmatizing or misleadingly narrow (e.g. "psychogeriatric patient," "mentally fragile," "confused elderly," "mentally ill elderly," "behaviourally disturbed," "mentally dysfunctioning," etc.); secondly, to emphasize that what is at issue is not only individual pathology but a disruption in the interaction of the individual with his/her environment, necessitating attention to psychosocial and organizational factors, as well as biological and intrapsychic factors. This broader focus is consistent with emerging concepts of mental health. The term is not meant to imply that all mental health problems are similar in cause, manifestation or severity.

problems for individual residents, their families, their fellow residents and facility staff. Examples of these different problems include behavioural difficulties (e.g. aggression, wandering, resistance to care); functional deficits (e.g. difficulties in feeding, dressing); memory difficulties (e.g. dangerous forgetfulness, repetitious questioning); psychotic symptoms (e.g. hallucinations, delusions); issues associated with competency (e.g. inability to consent to treatment); and intrapsychic suffering (e.g. depression, anxiety). Mental health problems can result from physiological, psychological or environmental (situational) causes. Frequently, several factors are involved. Mental health problems often coexist with physical health problems in residents of long-term care facilities.

3. TARGET SETTING

These guidelines cover services to elderly people with mental health problems when they are residents of long-term care facilities. A "long-term care" (LTC) facility is defined, for purposes of this document, as an institution which provides 24-hour shelter and services, including some professional health care components. The LTC facility definition includes hospitals when they are providing continuing or chronic care but not when they are providing acute medical/surgical care to this target group. Services provided to elderly people with mental health problems in their own homes, or in group-living situations without professional input, are not covered by these guidelines. However, these guidelines may still be useful for facilities without a professional staffing component and also for facilities providing services to people younger than 65, especially when the problems are similar (e.g. early dementia, stroke).

4. RATIONALE

The need for guidelines to address the special needs of this target group in LTC facilities has become evident for several reasons:

- There are now relatively large numbers of residents with mental health problems in LTC facilities, yet most facilities were not developed for this group. They were planned, staffed and programmed for residents with physical limitations or problems, who have different needs.

- Planning for those with physical health problems and for those with mental health problems in the same facility has raised a number of issues.

- The severity of the physical and mental problems manifested by people who are now being admitted to LTC facilities has increased, making the programming issues even more pressing.

- Because LTC facilities face a growing demand for high-quality care for all their residents, service organizations are seeking information for improving services, particularly services for residents with mental health problems and for other residents potentially affected by this target group.

5. OBJECTIVE

The objective of these guidelines is to help service-provider organizations to:

- Enhance the quality of life for the target group, their families, other residents and staff.

- Ensure that residents with mental health problems are provided with appropriate services.

- Ensure that individuals with reversible conditions (e.g. related to depression, infections, incorrect medications or environmental stress) are adequately treated.

- Ensure, for individuals with conditions which are not reversible (e.g. Alzheimer's dementia), that the conditions are managed in an effective and humane manner. As well, ensure that the frequently coexisting conditions (agitation, depression, paranoia, behaviour problems) are appropriately dealt with.

6. BACKGROUND

The reasons for the increasingly important role being played by LTC facilities in the provision of services to people with mental health problems include (1) changes in the mental health system; (2) improvements in systems for maintaining people with physical health problems in their own homes; and (3) changes in demographics of the Canadian population.

6.1 Changes in the Mental Health System

Thirty years ago the mental health system provided the bulk of short-term and long-term facility mental health care for the elderly. People with dementia, psychosis and other serious disorders were maintained in mental hospitals rather than LTC facilities, which were then viewed as appropriate only for those with physical health problems. Approximately half the mental hospital beds in Canada were occupied by people over the age of 65. Since the 1950s, however, the number of mental hospital beds has dropped dramatically. Many older patients were discharged to LTC facilities as part of this downsizing (deinstitutionalization) movement. Moreover, when the mental hospital beds were closed, most of the new elderly clients who previously would have been maintained in hospitals were directed instead to LTC facilities.

6.2 Changes in Home Support Systems

Systems for maintaining people in their own homes (home care, home nursing, day care, respite, etc.), thereby reducing the rate of admission to LTC facilities, have been more successful for clients with physical problems than for those with mental health problems. In some instances, adequate home support services could also delay institutionalization of individuals with mental health problems. Many difficulties, such as wandering, dangerous forgetfulness, aggression and disturbed sleep patterns, require 24-hour vigilance. Family caregivers, most of whom are elderly themselves, often persevere for years, but the constant burden of care eventually overwhelms them despite good support from home support services. Hence, facility care is sought for those with mental health problems at a relatively higher rate than for those with physical problems.

6.3 Demographic Changes

Changes in the demographics of the Canadian population have resulted in increasing numbers of residents with mental health problems. This is because some mental health problems show a marked increase in prevalence with increasing age, and the Canadian population is aging rapidly, especially the over 85 years age group. Dementia, as a notable example, has a prevalence rate of about 1.5 percent for those aged 65 to 74, but this increases to 27 percent for those 85 and older.

7. IMPLICATIONS OF MENTAL HEALTH PROBLEMS FOR LTC FACILITIES

These increases in numbers of elderly people with mental health problems are obviously important for service-provider organizations, but their significance is compounded by the fact that residents with mental health problems have different needs than residents with physical health problems. All residents have the same basic human needs (food, shelter, respect, medical care, etc.) but those with mental health problems have special group and individual needs as well. These needs can relate to the symptoms of a particular mental disorder or can involve the residents' interactions with their families, other facility residents and the staff. Issues include problem behaviours (aggression, wandering, resistance to care, etc.); questions associated with competency to make decisions (consent to treatment, etc.); functional deficits (feeding, dressing, etc.) psychotic symptoms (e.g. hallucinations, delusions); and intrapsychic suffering (depression, anxiety, etc.). In order to meet residents' needs and effectively address their problems, the facility board and management must consider an array of such issues.

8. COMPANION DOCUMENTS

Other documents should be read as companion pieces to these guidelines. These include Health and Welfare Canada publications *Adult Long Term Institutional Care* (1984) and *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* (1988). This latter document provides the principles and framework for the present guidelines, which do not address in detail the physical design of facilities for this target group because a separate document – *Designing Facilities for People with Dementia* – is being developed on that topic. It is also expected that there will be a series of documents produced by Federal/Provincial/Territorial groups which will be relevant for this target group. A number of helpful publications in this field have been selected for the bibliography. It is hoped that this document will be helpful to those charged with the responsibility of planning and managing services for this important group of people with mental health problems who live in LTC facilities.

■ CHAPTER 2
DESCRIPTION AND NUMBERS OF CLIENTS

These guidelines have been prepared to assist in the planning and delivery of care to elderly individuals who live in long-term care facilities and have mental health problems that manifest themselves in emotional distress, physical symptoms, poor social functioning and/or problem behaviours. Mental health problems are often the main reason for admission to LTC facilities, although they may also arise after the resident has been living at the facility for a period of time. The prevalence of some mental health problems increases with age, and the average age of residents of LTC facilities is likely to continue to rise. As the population ages, there will be increasing numbers of very old and frail elderly persons with psychiatric disorders, especially disorders affecting cognitive abilities (e.g. dementia) and mood (e.g. depression). This chapter describes this "target group" of elderly residents in terms of typical psychiatric diagnoses (see Table I) and problem behaviours (see Table II) and reviews the epidemiology of these mental health problems (see Table III). Available information about the demography of such residents in LTC facilities is also outlined. This information is essential for a full understanding of the system of services required by this group.

1. MENTAL DISORDERS

Table I, which shows the psychiatric disorders most frequently seen in the elderly, is based upon the Revised Third Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R), published by the American Psychiatric Association (1987). The estimated prevalence of psychiatric disorders among residents of LTC facilities varies from 52 percent to 94 percent, with some form of organic mental syndrome (especially dementia) being the most prevalent. Table III summarizes the four most recent studies of LTC facility populations that have included diagnoses of specific psychiatric disorders.

TABLE I

PSYCHIATRIC DISORDERS MOST FREQUENTLY SEEN IN THE ELDERLY IN LTC FACILITIES (based on DSM-III-R Diagnoses *)

Organic Mental Syndromes and Disorders
- Dementia (e.g. Alzheimer's disease, Multi-infarct dementia)
- Delirium
- Amnestic Syndrome

Mood Disorders
- Major Depression
- Bipolar Disorders
- Dysthymia (or Depressive Neurosis)

Schizophrenia

Delusional (Paranoid) Disorders (e.g. Paraphrenia)

Psychotic Disorders not elsewhere classified

Psychoactive Substance-use Disorders

Adjustment Disorders

Anxiety Disorders

Somatoform Disorders (e.g. Hypochondriasis)

Psychological Factors Affecting Physical Condition

Personality Disorders

* (American Psychiatric Association 1987)

TABLE II

PROBLEM BEHAVIOURS CATEGORIZED BY MOST FREQUENT UNDERLYING CAUSES

I	**ANGER**	lack of cooperation non-compliance verbal abuse tantrums physical aggression noise making destruction of property
II	**ANXIETY/FEAR**	obsessive behaviours importuning (pleading, repetitive requests) regression noise making waking others up
III	**DEPENDENCY**	importuning poor motivation excess disability
IV	**DEPRESSION**	withdrawal and apathy: non-participation in groups not forming relationships suicidal behaviours: refusal to eat refusal of treatment other self-harm
V	**PSYCHOSIS**	hallucinations: (responding to abnormal perceptions as if they were real) delusions: (abnormal thought content, fixed, false ideas, e.g. suspiciousness, paranoia)
VI	**COGNITIVE IMPAIRMENT**	repetitious questioning rummaging, hoarding wandering disrobing noise making inappropriate voiding sexual inappropriateness

TABLE III

EPIDEMIOLOGICAL STUDIES OF MENTAL DISORDERS IN LTC FACILITIES

Overall Prevalence	Organic Mental Disorders	Other Mental Disorders	Reference
52%	30%	22%	Alberta Health 1988
68%	39%	29%	Burns et al. 1988
85%	46%	39%	Teeter et al. 1976
94%	84%	10%	Rovner et al. 1986

The Alberta Health and Mental Care Study (1988) surveyed all 12,934 residents of Alberta's provincial long-term care facilities in the fall of 1988. The other three studies included in Table III were random-sample studies of selected nursing homes in the United States. (For example, Burns et al. [1988] studied 526 residents of 112 nursing homes as part of the National Nursing Home Survey Pre-test.) These latter three studies are not able to provide the breadth of the Alberta study, which covered all seven levels of care in that province.

Included in their "Residents with Mental Problems" group were those with current active diagnoses[3] which appeared in the medical record. In the study by Teeter et al. (1976), two thirds of the psychiatric disorders had been previously undiagnosed.

3 "Mental problems" diagnoses were recorded according to the International Classification of Diseases, Ninth Revision (ICD-9), and included chronic alcoholism, Alzheimer's disease, arteriosclerotic dementia, chronic organic brain syndrome, depression, mental disorder (non-psychotic) following organic brain damage, mental retardation, organic personality syndrome, presenile dementia, psychosis, schizophrenia, senile dementia, senility without psychosis, and other mental problems.

1.1 Organic Mental Syndromes

This heterogeneous group of disorders can be subdivided into acute (delirium) and chronic (dementia) conditions. The essential feature of all these disorders is a psychological or behavioural abnormality associated with transient or permanent dysfunction of the brain (American Psychiatric Association 1987). Brain dysfunction is reflected in an impairment of cognitive abilities (which include language, reasoning, memory, and visuospatial skills). The nature and severity of any cognitive impairment depends upon which areas of the brain are dysfunctional and the degree of that dysfunction. For example, the only observable cognitive change in someone who is in the very early stages of Alzheimer's disease might be a problem in remembering new information. The same person may still be able to speak, think and reason clearly. At this early stage, only a relatively small area of this person's brain is dysfunctional. As the extent of brain dysfunction increases, so does the amount of cognitive impairment. As mental abilities decline, behavioural flexibility is reduced and both psychiatric and social difficulties can ensue. Table IV outlines the most common behavioural changes associated with the course of Alzheimer's disease. There is typically more variability of symptoms in the early stages of the disease than in the later stages.

Distinguishing treatable causes of cognitive impairment

It is essential that potentially reversible or treatable causes of cognitive impairment be sought and treated. For example, depression in the elderly may be characterized by marked cognitive impairment (so-called "pseudodementia") which is reversible, or at least partially reversible, by treatment with antidepressant medication or other proven non-drug therapies. Physical illnesses, such as hypothyroidism, vitamin B12 deficiency, cardiac insufficiency, infections, dehydration, drug intoxication and other medical conditions common to the elderly, can also affect cognition in ways that resemble a dementing illness, but are potentially reversible with treatment. Sabin and associates (1982) found that almost 25 percent of nursing home residents with organic mental disorders had potentially reversible conditions.

Rovner et al. (1986), studying the residents of an intermediate-care facility, found the following prevalence of types of dementia:

Alzheimer's disease	56%	
Multi-infarct dementia	18%	
Parkinson's Disease with dementia	4%	
Other Organic Mental Disorders	6%	
TOTAL	84%	(See Table III)

The 6 percent with "Other Organic Mental Disorders" were delirious (i.e. acutely confused) and in all cases this delirium was due to drug intoxication.

In addition to the above, alcohol-related organic mental disorders also need to be considered in an LTC facility population. Examples include unexplained delirium related to "closet" drinking, dementia associated with alcoholism, and alcohol amnestic disorder (Korsakoff's syndrome).

TABLE IV

STAGES OF ALZHEIMER'S DISEASE: COMMON BEHAVIOURAL CHANGES

Stage	Neuropsychological Changes	Psychiatric Changes	Social Changes
EARLY: Mild Cognitive Decline	**Memory:** Forgetful - "loses" things. Difficulty remembering recent events. **Reasoning:** Poor judgement. Loss of mental flexibility. **Language:** Word-finding difficulties. Mild problems in understanding what is said. **Visuospatial:** Difficulty copying drawings. Disoriented - gets lost in familiar surroundings.	**Personality:** Become "more like themselves." Lack of inhibition. **Anxiety:** Variable degrees. **Depression:** Variable. **Suspiciousness:** Variable.	**Community Affairs:** Difficulties with work and in social groups. Difficulties driving a car. **Home Chores & Hobbies:** More difficult chores abandoned. Unable to do more complicated hobbies and maintain interests. **Personal Care:** Needs occasional prompting with self-care.

TABLE IV (continued)

STAGES OF ALZHEIMER'S DISEASE: COMMON BEHAVIOURAL CHANGES

Stage	Neuropsychological Changes	Psychiatric Changes	Social Changes
MIDDLE: Moderate Cognitive Decline	**Memory:** Severe difficulty in learning or remembering new information. Difficulty in recalling old knowledge. **Reasoning:** Difficulty in organizing and carrying out activities. Social judgement usually impaired. **Language:** Aphasic: Severe difficulty in understanding what is said and in speaking. **Visuospatial:** Visual agnosia (inability to attach meaning to sensory impressions), severe in some cases.	**Personality:** Flattening of affect. Lack of insight. **Anxiety:** Very common (obsessiveness, agitation, restlessness). **Depression:** Variable. **Psychosis:** Delusions (e.g. Capgras syndrome). Hallucinations. **Behaviour:** Occasional violence.	**Community Affairs:** Unable to function independently outside of the home. **Home Chores & Hobbies:** Able to do simple hobbies. Very restricted interests. **Personal Care:** Requires assistance in dressing, hygiene, keeping of personal effects.
LATE: Severe Cognitive Decline	**Memory:** May forget name of spouse. Unable to recognize familiar faces (including own face). **Reasoning:** Unable to make judgements or solve problems. **Language:** May be mute. **Visuospatial:** Visual agnosia common.	**Depression:** Sleep disturbances. **Behaviour:** "Dangerously" disorganized.	**Community Affairs:** None. **Home Chores & Hobbies:** None. **Personal Care:** Requires much help. Often incontinent.

Adapted from Cummings and Benson 1983: Hughes et al. 1982; and Reisling et al. 1982.

Mental health problems associated with organic mental syndromes

A wide variety of emotional, motivational, and behavioural abnormalities are associated with organic mental disorders. It is often impossible to determine whether the symptoms are the direct result of damage to the brain or are, in part, a reaction to the cognitive deficits and other psychological changes that constitute the essential features of these disorders (American Psychiatric Association 1987). Dementia is frequently associated with other psychiatric symptoms, including psychotic symptoms (delusions and/or hallucinations), depression, and anxiety. Prevalence of psychosis with dementia varies between 31 percent and 70 percent (Teeter et al. 1976; Rovner et al. 1986). Rovner et al. (1986) also reported that the psychotic residents in their study were significantly more demented and more behaviourally disturbed than the other residents. Fifteen percent of their dementia group had a co-existing depression. It is important to emphasize, however, that not all residents with cognitive impairment suffer from related mental health problems.

Physical problems associated with organic mental syndromes

It is also important to understand that many residents with organic mental disorders have associated physical problems affecting their ability to function (e.g. problems with dressing, eating, bathing, continence). Some of these problems are mainly due to physical changes frequently associated with aging (e.g. decline in physical strength, hearing and vision); others are due to the loss of cognitive or motor skills as a result of deteriorating brain function. Still others are due to concurrent physical disease (heart, lung, arthritis, diabetes) and other common medical problems of the elderly. Often, because of the progressive nature of some dementias, these associated physical and self-care problems will get worse over time.

1.2 Mood Disorders

Depression is the second most common disorder reported in LTC facility residents, affecting nearly one quarter of them (Burns et al. 1988). The psychosocial and physical losses in later life are believed to predispose many elderly people to depression. However, community-based studies using strict diagnostic criteria for severe depression have not reported higher prevalence among older persons than among younger adults. Depression is far more common in institutionalized elderly people than it is among community-dwelling elderly people. Prevalence figures for depression in LTC facilities

vary considerably depending on the definition of depression that is used and the demography of the resident population in the facility. In Edmonton, Alberta, Bland (1988) found that approximately 10 percent of the residents fulfilled the DSM-III criteria for a major depression or dysthymic disorder. In the U.S. National Nursing Home Survey (Burns et al. 1988), which examined chart-recorded diagnoses for residents, nearly one quarter carried a diagnosis of depression. In a subsequent American study of the institutionalized aged (Parmelee, Katz and Lawton 1989), close to 40 percent demonstrated major or minor depressions. Major depressions were frequent among newly admitted residents.

Of the studies included in Table III, Burns et al. (1988) determined the prevalence of depression to be 5 percent, Rovner et al. (1986) found it to be 8 percent, while Teeter et al. (1976) identified it at 26 percent. These data provide valuable insights and allow for anticipation of psychiatric problems and rational planning of service requirements.

Table I lists the DSM-III-R diagnoses listed under the heading of Mood Disorders. Depression is often overlooked in elderly individuals, as its presentation can be very different or "atypical" when compared to those younger than 65, and because it is frequently associated with physical illness (Wasylenki 1980). Table V shows the characteristic presentation of depression in the elderly, outlining the "Form" of the illness as well as the usual symptomatology – "Content." Older people are less likely to complain of depression and more likely to feel, instead, that their symptoms are related to normal aging or physical illness. If the depression is not resolved, apathy, regression, an attitude of helplessness, behavioural disturbance or even suicide may result. Given the success rate of pharmacological treatment and other treatment modalities of depression, it is important that caregivers be alert to the possible presence of depression. Care must be taken, however, to recognize side effects of medications and to use appropriate dosages. Note that treatable depression may coexist with dementia or other psychiatric disorders.

1.3 Other Mental Disorders

Limited information is available about the prevalence in LTC facility residents of the other psychiatric disorders listed in Table I. It is estimated that approximately 10 percent of the general population over 65 are troubled by anxiety, adjustment disorders, psychoses and substance abuse. Prevalence in LTC facilities of mental disorders, other than organic mental syndromes and depression, has been reported in three studies. The reported prevalence ranged from 2 percent

(Rovner et al. 1986) to 13 percent (Teeter et al. 1976) to 24 percent (Burns et al. 1988). These other mental disorders included (in decreasing order of prevalence), schizophrenia, other psychoses, anxiety disorders, hypochondriasis, and personality disorders. Their prevalence, however, was relatively low compared to the prevalence of organic mental disorders in these LTC facility populations.

2. PROBLEM BEHAVIOUR

Behaviour is anything a person says or does. A behaviour becomes problematic when it disrupts the relationships between an individual, his or her social group and the broader community in which he or she lives. See Table II for a breakdown of problem behaviours categorized by the most common underlying causes.

Problem behaviours are diagnostically non-specific. They can result from a complex interplay between personality, medical/physical problems, psychiatric illness, and/or social factors (such as overwhelming losses). For many residents, their complex, difficult-to-treat medical and/or physical conditions can be the main cause of behavioural problems. The Alberta study (1988) measured the frequency of 14 examples of specific behaviours in their long-term care institutional population. For analysis, the total population was divided into two groups: those without mental diagnoses and those with mental diagnoses (see page 10 footnote for list of diagnoses). Fifty-eight percent of the group with mental diagnoses had some form of dementia. Table VI lists 12 of the behaviours studied and the percentage of residents exhibiting them in each group. When different diagnostic classes were examined, it was found that 29.9 percent of residents with no mental health diagnoses exhibited no problem behaviour, while 70.1 percent exhibited at least one problem behaviour.

The largest U.S. study of the prevalence of behaviour problems in LTC facilities demonstrated that an average of 64 percent of residents showed "significant" behaviour disturbance (Zimmer et al. 1984). While 66 percent of these residents also had diagnoses indicating organic mental disorder, very few had specific psychiatric diagnoses and only 15 percent had received psychiatric assessment. Rockwood, Stolee and Robertson (in press) in Saskatchewan have shown an increase in prevalence of problem behaviour in the higher levels of care and a high positive correlation between degree of cognitive impairment and frequency of problem behaviour. Similar correlations have been consistently reported in other studies (Rovner et al. 1986; Zimmer et al. 1984).

An inherent difficulty in studies of this type is that identification of a "problem behaviour" can be a very subjective process. For example, if a cognitively impaired resident is living in a facility which is designed to handle his aggressive behaviours (e.g. by providing a private room) and has sufficient numbers of trained staff to interact with him, there may be no reports of "problem behaviours." In many cases, the reporting of problem behaviours tells us more about the resources of the facility than about the residents themselves.

TABLE V

CHARACTERISTIC PRESENTATION OF DEPRESSION IN THE ELDERLY

FORM:	Increasingly severe with age
	Episodes last longer
	Recurs with increasing frequency
CONTENT:	Somatic preoccupations
	Hypochondriacal complaints
	Anxiety, "jittery restlessness"
	More agitation, less retardation
	Irritability
	Loss of interest and motivation
	Fatigue
	Importuning
	Self-reproach
	Psychosis; paranoid ideation, delusions
	Cognitive disturbance ("pseudodementia")
	Suicidal preoccupation

TABLE VI

PROBLEM BEHAVIOURS: COMPARISON BETWEEN RESIDENTS WITH AND WITHOUT ICD-9 MENTAL PROBLEMS DIAGNOSES (Adopted from Alberta Health Study *)

Behaviour	Without Mental Problems N = 5,249		With Mental Problems (Inc. Dementias) N = 7,008		With Dementia N = 3,702	
	n.	%	n.	%	n.	%
Acts sad, depressed or withdrawn	1,719	33	2,772	40	1,277	34
Agitation	956	18	2,389	34	1,443	39
Aggressive	626	12	1,656	24	992	27
Angry, hostile	446	8	1,113	16	629	17
Dangerous wandering	162	3	871	12	664	18
Refuses care (does not comply)	273	5	632	9	371	10
Demands attention constantly	375	7	512	7	223	6
Suspicious (interferes with daily routine)	118	2	405	6	193	5
Hoarding, rummaging	92	2	341	5	216	6
Inappropriate smoking, (frequent,unsafe)	160	3	309	4	132	4
Inappropriate sexual activity	135	3	78	1	67	2
Alcohol or drug abuse	20	<1	86	2	16	<1

Total numbers of residents = 12,257.

(Adopted from Province-Wide Patient Classification, Alberta Department of Health, 1988)

3. WIDER IMPACT OF MENTAL HEALTH PROBLEMS

The resident population of a typical LTC facility is mixed, including, for example, both physically frail, cognitively intact individuals, and physically healthy individuals with advanced dementia or other mental disorders. Mental health problems affect not only the people who manifest problem behaviours but also their fellow residents, the families of residents, and the professional and volunteer caregivers. Addressing a mental health problem, therefore, requires more than treating individual pathology or removing a particular environmental "trigger." It means taking into account the behaviours, needs and well-being of the people in the psychosocial environment. The attitudes and reactions of these other people will, to a large extent, determine what constitutes a problem behaviour.

One recent study (Vernier and Small 1988) identified five behaviours that had been singled out by nursing staff as disruptive.[4] Residents, on the other hand, rated those same behaviours as "not noticeable, or noticeable but not disruptive to my living environment"; instead, they were most upset by someone "entering the wrong room."

4. CONCLUSIONS

It is clear from this brief review of the epidemiology of mental health problems among LTC facility residents that there is a very high prevalence of both psychiatric illness and problem behaviours. This points to the great need for these facilities to develop mental health services and to train their staff to work with residents who manifest these problems (see Chapter 9 – Service Capacity and Staffing). There must also be a major shift in perception about the role of the LTC facilities. Clearly, their mandate must be seen to include not only physical care and shelter but also psychological and social care.

In planning services, it is important to use all available local information about the epidemiology of mental health problems and problem behaviours, since current prevalence and foreseeable trends in a particular facility will vary according to several variables. Clear and consistent policies governing assessment and record keeping will help to ensure that the necessary data are available.

4 These behaviours were "troublemakers perceived as being lucid and/but purposely irritating; verbal assault; physical assault; behaviour exhibiting destruction of others' property; and threatening behaviour where there was a perception of the possibility of physical harm."

CHAPTER 3
PRINCIPLES OF CAREGIVING

The following principles of caregiving reflect the philosophy and approach of this document.

1. **Every resident is an individual with a full range of human needs and rights.**

   All residents have a right to appropriate care, including environmental, recreational, therapeutic and other programs adapted to their needs.

   Some residents, because of their mental health problems, may only be able to voice their deepest needs indirectly, through behaviour that is seen by onlookers as disruptive. If the underlying need is understood and met, the disturbing behaviour may be eliminated, reduced or at least more easily managed.

2. **The long-term care institution is, first and foremost, the resident's home.**

   The environment must be made as homelike as possible to create a feeling of security and comfort. Clinical and institutional features should be minimized. When cognitive impairment is a factor, adapted environments can help to overcome certain deficiencies. Any intervention or modification of the physical and psychosocial environment must be in the direction of creating a better-quality, more human milieu with due regard to safety and labour-saving efficiencies to improve staff/resident ratios.

3. **The needs of each resident must be addressed through the implementation of an individualized care plan which supports the resident's capacity for independence.**

   A care plan detailing the interventions, services and environmental adaptations required must be established and followed up for each resident. The goals of the plan are to provide an optimal quality of life, to maximize the person's residual capabilities, to prevent illness and to control the symptoms of unpreventable illness.

Supportive interventions must meet the resident's needs without undermining his/her capacity to make choices and exercise abilities. The individualized care plan should be carried out by an interdisciplinary team with appropriate training, skills and attitudes, in cooperation with informal caregivers (family and friends). Because no single institution can meet all needs, the resident must have access to the community's health care and social services network and other formal and informal resources of the community.

4. **Residents with different diagnoses share certain needs, but do not always benefit from the same interventions.**

Residents with cognitive impairment, those with mood disorders, those with other psychiatric diagnoses and those who are physically frail but free of mental disorders have some needs in common. However, they also have distinct needs related to their diagnoses and their individual characteristics and problems.

It is essential to find a balance that will respect the needs of each group being served by the facility. If integration of these groups in the same spaces and activities is doing residents more harm than good, it will be necessary to pursue alternatives.

5. **The staff require support.**

Care of residents with mental health problems is taxing on the staff. To support staff in their work, adequate training must be provided, as well as adequate numbers of staff to meet the needs of residents. Staff can benefit from formal and informal opportunities to discuss the problems and successes they encounter. Management should provide a supportive atmosphere and provide consultation to assist with difficult situations.

6. **The families, significant others and volunteers require support.**

The contribution of families, significant others and volunteers is essential. In a spirit of partnership, the long-term care facility should provide information, recognition, professional backup, support and encouragement to informal caregivers. Their participation helps to keep residents in touch with the wider community and helps to meet residents' needs for emotional support, stimulation, and valued social roles (e.g. as parents and grandparents). The presence of these informal caregivers also benefits other residents.

■ CHAPTER 4
SERVICES EXTERNAL TO THE FACILITY

INTRODUCTION

While the focus of these guidelines is on the resident with mental health problems living in a long-term care facility, it is important to recognize the vital role that services external to the facility can play in the resident's care. The facility is but one component in a continuum of long-term care and mental health services (see Health and Welfare Canada 1988a and 1988b).

1. IMPORTANCE OF EXTERNAL SERVICES

Services provided by agencies outside the long-term care facility are important to the facility for several reasons:

1. Pre-admission assessment and planning – provided externally – can direct some potential admissions to other appropriate community-based services (e.g. home support, day care, respite, mental health consultation, etc.).

2. Appropriately admitted residents will need services from professionals and other community-based services in the form of clinical reviews (e.g. pharmacy, medical, etc.) and also to address problems arising in the facility (e.g. mental health consultation, rehabilitation consultation, etc.).

3. From time to time the resident may need short- or longer-term admission to a service external to the long-term care facility in order to meet his/her needs (e.g. admission to a general hospital for assessment or treatment, admission to a psychiatric day or inpatient unit, etc.).

4. The long-term care facility itself may be an important resource to other agencies offering client services (e.g. respite, day care, etc.) or education and consultation (e.g. to home caregivers, homecare agencies, etc.). Effective collaboration promotes the well-being of clients in all settings.

2. TYPES OF EXTERNAL SERVICES

The range of external services required by a particular facility will depend upon the availability of "in-house" services. Generally, larger facilities may have more in-house services, such as in-house medical staff, pharmacy and occupational therapy, while smaller facilities will have to obtain these from external agencies.

Services external to the facility include both those which come into the facility or those to which the resident is transferred. Services brought into the facility to address the needs of people with mental health problems may include: physician services (general practitioner, geriatrician, geriatric psychiatrist); pharmacy; specialist nursing; psychology; social work; rehabilitation (occupational, physiotherapy). Often these specialists will work in interdisciplinary teams. Volunteers and members of the family are also considered part of this category.

Services to which residents may be transferred for assessment, treatment, rehabilitation or other assistance include general hospitals, psychiatric community or hospital services, and other health and social services addressing their needs.

3. REFERRAL CRITERIA

In order to guide staff both in the facility and in the external agency, it is important to develop criteria for appropriate referral. These referral criteria should be developed cooperatively by the facility and the external agency. Some referral criteria may be more problematic than others. For example, when to refer a resident for inpatient psychiatric care may be an issue. The difficulty can often be alleviated by having the inpatient facility staff involved with the resident in a consultative capacity before the question of inpatient admission arises.

4. ROLE OF EXTERNAL STAFF IN THE FACILITY

The facility should develop an atmosphere that will permit the external staff to feel that they are part of the care team and not "visiting firefighters." Visiting staff must have formal approval from the administrator to practice in the facility. Appropriate policies and procedures should be in place to make sure that information needed by the external staff is readily available, that good communication exists between internal and external staff, and that the external staff clearly communicate their findings, directions and suggestions. Team conferences are recommended. Visiting staff should document all findings and results on the resident's chart.

5. TRANSFER PROCEDURES

Sometimes it is not possible to meet the resident's needs in the long-term care facility and a physical transfer must be made. Residents with dementia and other mental health problems are particularly susceptible to the stress of transferring from familiar surroundings to a new environment. The transfer itself may result in disturbed behaviour.

Because of the risk of harmful effects, transfers should take place only when necessary for the benefit of the resident and not just for facility convenience. Before a transfer is considered, a concerted effort must be made to meet the needs of the resident on-site (e.g. through consultation with external experts, special programming, etc.). However, when required, transfers must be made promptly and carefully with the needs of the resident kept in mind.

All necessary information should be transferred to the outside agency to help the external service staff deal with the known and anticipated problems. Familiar staff accompanying the resident might help reduce stress for the resident and provide information to the external agency. The cooperation and assistance of family members is also invaluable in facilitating the transfer.

6. COORDINATING MECHANISMS

Coordination of internal and external services is essential for effective and efficient delivery of services to residents with mental health problems (Health and Welfare Canada 1988b). While coordination is frequently accomplished by day-to-day communication about individual residents, it is often useful to establish other mechanisms of coordination. These include:

- contracts for service
- joint regular meetings
- joint appointments for staff
- joint appointments on governing boards
- appointment of resident case managers who liaise with external professionals
- involvement of the family physician in coordinating medical care
- involvement of family or a volunteer as an advocate for the resident.

CHAPTER 5
PRE-ADMISSION AND ADMISSION PROCESS

1. PRE-ADMISSION ASSESSMENT

The purpose of a comprehensive pre-admission assessment is to determine the most suitable option to meet the care requirements of the individual. This assessment establishes diagnosis and describes objectively and comprehensively the resident's strengths, needs and problems to determine the most appropriate services for the individual. The content and process of a comprehensive assessment (e.g. medical, functional, etc.) are discussed in detail as part of the care process described in Chapter 6.

The assessment also considers the ability and motivation of the primary caregiver (spouse, relative, or significant other) to provide care for the client at home; this is an important factor in determining service requirements. The assessment can be carried out in a variety of settings, but the client's own home is preferable. Typical situations leading to consideration for admission arise where an elderly spouse can no longer cope with the applicant's dysfunctional behaviour and care requirements. For example, the applicant may, because of dementia or other mental health problems, sleep poorly, wander away and require extensive help in dressing, toileting and other activities of daily living. The extent of the behavioural problems and the burden of care may strain or exceed the ability of the spouse to continue, even with the aid of community and home support services.

When all other supports and interventions have been implemented and are not able to meet the needs of the client and the caregiver, then institutional care should be considered.

It is recommended that, following the comprehensive assessment, an interdisciplinary team make the final decision as to whether the client can be maintained in the community or whether he/she should be admitted to a long-term care facility.

The decision about which facility the client should enter will be made in consultation with the individual and the family. Systems governing the placement process vary from province to province; models include the facility-based admission committee, the district placement committee and the Single-Entry Model (Health and Welfare Canada 1988a).

2. PRE-ADMISSION PLANNING

It is recommended that one person maintain primary contact with the individual and family during the pre-admission process and act as interim or ongoing case manager.

Specifically, the case manager:

- relates to the client on an individual basis.
- reviews choices and arranges tours and visits of facilities for the client and families, so they can become familiar with programs and services offered.
- integrates and transfers, to the receiving facility, referral data and the data from the comprehensive pre-admission assessment.
- updates the comprehensive assessment if the individual's condition changes or if three months have passed prior to admission.
- explains the appeal process that is available if the facility offered does not meet the expectations of the individual and family.

3. PRE-ADMISSION ORIENTATION

The case manager should arrange one or more meetings between the applicant and family and the staff of the long-term care facility to facilitate the admission process. The meeting(s) will acquaint the applicant and family with the philosophy of care and the services provided. The meeting should also ensure that the family understands the facility's expectations, and it should encourage family participation in the planning of care. The facility should provide written information clearly outlining all facility policies and procedures and the care services available.

An important aspect of the first meeting is to encourage the resident and family, which may include friends or significant others, to attend the interdisciplinary team meeting, as well as future meetings, on a regular basis. At these meetings an individualized plan of care for the new resident will be developed and updated. By stressing the importance of family input to the plan of care, and by adapting the plan to meet family concerns when possible, staff can encourage family involvement.

If at the time of assessment an applicant is deemed to require a guardian and/or trustee, pre-admission planning should include discussing with the family or other responsible party what this entails. It is expected that appropriate action will be initiated by the family prior to admission. For additional details see Chapter 11, "Legal and Ethical Issues."

The staff involved in the pre-admission planning must assess the care needs of all family members concerned and must be aware of the difficulties that both the applicant and the family face in adjusting to this major change in their lifestyle. The client may feel angry, resentful or neglected by the family. The family may experience feelings of guilt, anger or frustration that they are no longer able to care for their loved one. The staff should respond by reassuring the individual and family as they plan for this stressful change in their lives. Whenever possible, the individual with mental health problems must be included in family discussions about his/her admission to a long-term care facility. Involving cognitively impaired or depressed residents in such meetings obviously requires sensitivity and adapted approaches.

4. ADMISSION TO THE LONG-TERM CARE FACILITY

New residents and families who have had a pre-admission orientation will have a better understanding of what to expect. Residents admitted under emergency conditions will usually take longer to adjust to the changed situation, as will their families. It is very important that staff understand the emotional trauma experienced by the new residents and how they and their families perceive these changes.

The referring agency and placement committee must ensure the prompt transfer of all pertinent information to the receiving facility. This information will be required to orient the staff to the new resident and to identify other necessary steps for ensuring the health and comfort of the new resident.

Orientation of the new resident and family to the facility will include:

- Introductions to the key caregivers. (Caregivers should continue to introduce themselves until the new resident responds without cuing by the staff.)

- Procedures (e.g. providing written information) that recognize the inability of the new resident to retain information on his/her immediate arrival.

Staff and family should understand that symptoms of the mental health problem may increase due to the stress of transfer and the unfamiliar surroundings.

Time frames for completing individual admission and orientation procedures should be realistic. It is important to arrange a convenient time for the family to attend the interdisciplinary conference. Being involved in the initial care-planning conference will help in the period of readjustment for family and resident and will ensure that family members understand and fulfil their roles as key contributors to the development of an individual care plan.

Ongoing reassurance, support, encouragement and education are required for the new resident and family through this transition from one lifestyle to another.

■ CHAPTER 6
PROBLEM SOLVING AND THE CARE PROCESS

"CARE PROCESS" DEFINED

A systematic care process must be developed by the facility to address the needs of each resident with mental health problems. The care process can be thought of as a systematic approach to problem solving. The care process begins with the identification of the resident's problems, strengths and needs. The causes of the problems are then determined. This permits staff to formulate a plan to address specific problems and optimize the quality of life for each resident through medical, social and environmental means.

The care process uses a systematic problem-solving approach. Table VII shows the conceptual steps in the care process. Although the steps appear to be sequential, often two or more elements of the process are developed simultaneously. For example, when identifying problems, strengths may be identified and tentative hypotheses formed about the causes of the problems.

The processes of assessment, searching for the causes of the problems, formulation of the care plan and reassessment are discussed in detail in this chapter; intervention strategies are discussed in subsequent chapters.

1. ASSESSMENT

Assessment is the process of identifying, collecting, recording and evaluating information required to understand the resident's needs. The conceptual steps in the assessment include identifying the problems, discovering the immediate and indirect causes of these problems, and determining the strengths of the resident. The results of the assessment are then used by the interdisciplinary team to formulate the care plan.

A comprehensive assessment will include:

- a medical history and physical examination
- psychiatric history and evaluation
- review of prescription and non-prescription medication

- assessment of capacity for self-care in daily living
- social history and evaluation of social network and resources

(Adopted from Health and Welfare Canada 1988b).

The information for the assessment is gathered from a number of sources, beginning with the resident and including relatives, significant others, staff and professionals. Professionals must have appropriate credentials and specific expertise in working with elderly persons who have mental health problems.

The methods used to gather the information can include observation, interviews, and tests. Flow charts, such as the Behavioural Assessment Record (Kline 1986, page 5) and other devices which measure the frequency, antecedents and consequences of a behaviour, can be useful in identifying the significance of a particular behaviour and its causes.

The steps of the assessment are highlighted here, with particular reference to residents with mental health problems.

1.1 Identify Problems in Functioning (activities of daily living) and Behaviour

Behaviours or losses of function which are considered to be "problems" must be viewed in context. In some cases, the "problem" is in the eye of the beholder who has inappropriate expectations. Even more commonly, a behaviour or loss of function is identified as a problem mainly because of the setting in which it occurs. For example, wandering may be a very serious problem in a facility on a busy street with many exit doors. However, the same behaviour in an appropriately designed facility with secure areas for wandering is not a problem. Similarly, annoying behaviour, such as repetitious questioning, may be identified as a problem by some staff but not by others.

1.1.1 Problems in Functioning and Cognition

Functions necessary for daily living should be examined to identify problems and strengths. These functions include eating, toileting, dressing, ambulation, bathing, grooming, personal hygiene, communication, social interaction, leisure activities, sensory functioning, legal competency, cognitive abilities and any other function which might be affected by cognitive, emotional, or behavioural problems.

TABLE VII

CARE PROCESS STEPS

1. ASSESSMENT

Assessment of elderly residents with mental health problems is difficult and must proceed on a broad front. There should be a systematic search for remediable conditions and deficits – physical, mental and social. The approach should include investigation of all symptoms, of whatever origin, in the context of the resident's life situation and environment. The skills and expertise of specialists in relevant fields should be used and their joint observation compiled into a single comprehensive, interdisciplinary assessment. The following process forms the basis of diagnosis and permits the development of a management plan for the patient:

a. Identify problems in functioning and behaviour
b. Search for causes of the problems
c. Identify strengths.

2. FORMULATION OF THE CARE PLAN

The plan specifies all interventions, their timing and duration, how they will be monitored and evaluated, and who will be responsible for each aspect of the intervention.

3. INTERVENTIONS

Medical, nursing, psychiatric and other treatment services, environmental modifications, changes in staff approaches, specific program activities, etc. are carried out.

4. MONITORING AND REASSESSMENT

Interventions are evaluated and reassessed, for example, by asking:

- Did the intervention achieve the desired result?
- Were there harmful effects?
- Should the care plan be modified, and how?

A number of instruments have been developed by provinces and territories to assist in the systematic identification of these types of functional status problems. Examples of other instruments include the Barthel Index (Barthel 1965) and the Monthly Functional Evaluation Chart (Ontario Association of Homes for the Aged 1985).

To assess cognition, there are a number of brief screening tests available. The Folstein Mini-Mental State Examination (Folstein et al. 1975) is widely used. A word of caution must be added about possible abuses of a test of this type. Though administration of this test can be taught to health care professionals from a number of disciplines, the interpretation of the test results must be left to an experienced physician or psychologist. A resident may do poorly for a variety of reasons other than cognitive impairment. For example, an elderly person with depression may get a low score because she/he is not paying attention to the questions the examiner is asking. Interpretation of results usually depends more on the quality of the responses than the exact test score.

1.1.2 Behavioural Problems

Areas of problem behaviour which may be associated with mental health problems can include a large number of specific behaviours. The Alberta review (see Chapter 2), for example, includes these areas: depressed/sad/withdrawn; agitation; aggressive; angry/hostile; dangerous wandering; refuses care; demands attention; suspicious; hoarding/rummaging; inappropriate smoking; inappropriate sexual activity; alcohol/drug abuse. Other jurisdictions have similar lists to help guide the identification of problem behaviours.

Having identified the functioning and behaviour problems of the individual, the next step in assessment is to identify remediable and non-remediable causes and any contributing factors.

1.2 Search for Causes of the Problems

Facility management must be particularly sensitive to the need to develop clinical systems, including trained staff, which help to uncover the causes of problematic behaviour. The field is replete with alarming examples of inappropriate interventions (or lack of intervention) based on a misunderstanding of the causes of behaviour. A frequent error is to consider a behaviour to be an inevitable aspect of a

dementia, when in fact it is caused by a reversible medical, psychiatric or environmental condition. For example, loss of memory, withdrawal, and agitation with subsequent loss of self-care function might be attributed to a dementia, but could in fact result from a treatable depression. Aggressive, confused, noisy behaviour might suggest a dementia or a psychotic problem, but could turn out to be symptoms of medication toxicity. Seemingly irrational agitation may sometimes be traced to a painful physical condition in a person who cannot communicate verbally.

In the search for the causes of a particular problematic behaviour, it is a useful strategy to assume that the behaviour has meaning to the resident, even when this meaning is not immediately evident to an observer. This is particularly relevant for residents who have lost the ability to communicate verbally or to organize their thoughts and behaviours in a normal fashion. They tend to rely on their feelings to interpret their world and are often unusually sensitive to the emotional state of others. Excessive noise making (e.g. shouting, calling out) is a good example of a behaviour used by those who have lost the ability to speak. Their characteristic noise may be a non-specific expression of a variety of underlying feelings, such as anger, anxiety or confusion (see Table I). Ryan et al. (1988) found three major reasons for noise making: a) as a response *to* the environment (e.g. fear of a room-mate or experiencing sudden pain); b) for eliciting a response *from* the environment (e.g. to get attention); and c) for self-stimulation (e.g. because of deafness or social isolation). They found that in 12 percent of noisy residents the noise was "apparently purposeless."

The search for causes should always consider the medical, psychiatric and environmental/social domains.

1.2.1 Physical Causes

Medical illnesses or conditions can interfere with brain function and lead to a wide variety of cognitive, emotional or behavioural problems. Commonly occurring medical conditions that often cause such problems include infection, dehydration, constipation, pain, silent infarctions, lung disease, medication reactions, sensory loss, small strokes and urinary retention. There are of course many other medical conditions which might contribute to a problem behaviour.

The medical assessment of the causes of problems must be carried out by a qualified physician skilled in working

with elderly people who have difficulties in communication because of a dementia or other mental disorder.

1.2.2 Psychiatric Causes

The psychiatric syndromes which are the most likely to contribute to problem behaviours are discussed in more detail in Chapter 2. A useful reference is *Psychogeriatrics: A Practical Handbook* (Wasylenki 1987).

It is important to differentiate among the possible psychiatric causes of problem behaviours because some of the syndromes are treatable; other syndromes have symptoms which are manageable, even though the underlying disorder may not be reversible, as in the case of a progressive dementia.

Psychiatric syndromes that should be considered as possible causes of problems in functioning and behaviour include:

Depressive disorders (major Depression, Dysthymia)

Depression often displays different symptoms in an older person than in a younger person (See Chapter 2, Table V). Confusion, memory impairment and other cognitive problems are especially common in elderly people with treatable depression and may be wrongly attributed to dementia. The differentiation of depression from dementia is a very important diagnostic judgement because depression is eminently treatable. Depression may also result from a medical cause or an environmental cause. Residents with dementia may also have a treatable depression.

Delirium

Delirium is an acute brain dysfunction with manifestations including clouding of consciousness with global cognitive impairment; restlessness and apprehension or apathy; incoherent speech; and illusions, hallucinations, and delusions. Suspected dementia or acute psychotic disorder must be differentiated from delirium because delirium is usually treatable by addressing the underlying medical problems. Wasylenki (1987, page 76) provides a table to help differentiate delirium from dementia. Adverse drug reactions and infections are among the common medical causes of

delirium. A treatable delirium may also occur in a person with dementia or some other psychiatric diagnosis.

Dementia

It is important to differentiate dementia (Alzheimer's disease, multi-infarct, etc.) from delirium or depression, because a progressive dementia is not reversible. A wide variety of problem behaviours and difficulties in daily functioning can be attributed to dementing processes. It is often impossible to determine whether these symptoms are the direct result of damage to the brain or are instead a reaction to the cognitive deficits and other psychological changes that constitute the essential features of dementia.

Certain behaviours or symptoms seen in dementias (e.g. depression, agitation, pacing, sleep disturbances, aggression, etc.) may be relieved by appropriately prescribed medications or by other methods (e.g. by staff attitudes, programs, and appropriate environments).

Medication problems

While not a psychiatric syndrome as such, problems with medications, especially psychoactive medications, are such a common cause of problem behaviours that they deserve a special mention. For example, motor restlessness can be a side effect of major tranquillizers and may be misinterpreted as agitation. This leads to the dose being increased, causing even more problems. Problems with medications may also resemble a psychiatric syndrome such as depression, delirium, dementia, psychosis or anxiety.

Other psychiatric conditions

Other psychiatric conditions should also be considered as possible causes of problem behaviour, although they are usually less common than depression and dementia in long-term care facilities. For some residents, psychiatric conditions may have started well prior to the resident entering the facility. Since some conditions are cyclical, symptoms may reappear or be triggered by stresses in the facility. These conditions include mania, schizophrenia, paranoid disorders, anxiety disorders, adjustment disorders, personality disorders, developmental disorders (mental retardation), and disorders related to substance abuse (e.g. alcoholism).

1.2.3 Environmental/Social Causes

Problem behaviours can result from residents' reactions to their experiences in their living environment. This environment includes the building, the facility routines (e.g. bathing, feeding, access restrictions), staff, other residents, and other people who remain part of the residents' "psychological environment" even when not present in the facility. Sometimes environmental stresses are exacerbated by residents' psychological, cognitive or perceptual problems. Residents can respond with anger, anxiety and a number of other reactions which can lead to aggression, withdrawal and other problem behaviours.

Tools, such as flow charts, to measure the frequency of problem behaviours and identify situational and temporal triggers and the consequences of the behaviour (possible reinforcer), can be helpful in determining environmental/social causes of problem behaviour.

1.3 Determine Strengths

It is important to become familiar with the resident's strengths as well as his/her problems, since the strengths can often be enlisted to help address the identified problems. In addition, ensuring the best achievable quality of life for residents with a progressive dementia will depend on capitalizing on their remaining strengths, since there may be relatively few activities from which they can derive satisfaction.

Strengths should be assessed in the domains listed above; they include activities of daily living, hobbies and social skills. Knowledge about a person's past strengths is useful in orienting staff, and some remnants of these strengths may be activated. Knowledge of past achievements can also help staff relate to the resident as a person. It is also very important to recognize the strengths of the support network of the resident, such as visiting family or friends. These strengths are taken into account in formulating the care plan.

2. FORMULATION OF THE CARE PLAN

Care Plan Defined

The interdisciplinary care plan is a formal description, in writing, of what is to be done to address the resident's problems and needs, and who in the care team is to carry out these tasks. The care plan is formulated from the assessment which has identified the resident's strengths, as well as the problems and their causes. In formulating and modifying the care plan, it is important that staff be aware of the range of interventions which can be selected to address the problems and their causes.

Importance of the Care Plan

The care plan is critical to the success of the facility in meeting the needs of the resident. The care plan allows for continuity of care between various caregivers and becomes the focus for interdisciplinary collaboration and information exchange.

Content of the Care Plan

The written care plan communicates a concise, comprehensive and current summary of the resident's past and present status to all members of the health care team. It identifies problems solved and those yet to be solved, approaches that have been successful, and patterns of responses of the resident.

The care plan identifies the problems and needs that must be addressed and specifies expected outcomes or goals (urgent, short-term and long-term). Interventions to achieve these outcomes are specified. Responsibilities of the staff, resident and others involved in carrying out the interventions and activities in the care plan are clearly stated. Methods of monitoring and timelines for reviewing progress (reassessment) are listed.

The specified interventions to meet the problems and needs of the resident will include specific medical, psychiatric, environmental/social and other procedures or treatments, as well as structured activities (e.g. exercise, music groups, reality orientation, etc.). In addition, direction on the approach staff should take with residents in certain potentially stressful situations should be specified. An example would be "Mrs. J. is very sensitive to control issues, especially involving food. Allow her choices whenever possible and quiet time on her own to eat her meal."

Developing the Plan

Following the assessment activities, the care plan is best formulated in a team meeting including all those involved in the assessment process and all those who will be involved in the interventions and care of the resident. Participants will bring to the meeting their own ideas, observations and recommendations concerning the care of the individual, but should be prepared to modify and integrate them into the overall care plan. The meeting should include the resident and family, if appropriate.

Although it may require the presence of several people, a team meeting to formulate the care plan has many advantages:

- group discussion is an effective way to bring out the full range of the residents' problems and needs and to assess their priority;

- causes of problems are more likely to be accurately identified when information comes from a number of team members;

- in selecting and planning interventions, the perspectives of different team members will be useful and assigning responsibility for carrying out the tasks can be efficiently handled in the meeting; and

- finally, people who have been consulted and have participated in collective decision making about the care of a resident are more likely to fully understand the resulting care plan and be committed to carrying it out.

The written care plan should be accessible to all staff involved in the care process, with appropriate safeguards for confidentiality.

Format of the Care Plan

The comprehensive care plan must be in writing and cover the elements discussed above ("Content of the Care Plan"). Various formats have been developed to capture this information. The problem-oriented record is one systematic method, but the actual format is not as important as the team process described here to develop the care plan. Useful references on various aspects of the care-planning process are listed in the Bibliography of these guidelines (e.g. Doenges, Townsend and Moorhouse 1989; Ontario Association of Homes for the Aged 1985, etc.). In some record systems there may be sub-plans developed to link with the comprehensive overall care plan. For example, the occupational therapist may have a more detailed plan to fulfil the assigned responsibilities outlined in the overall care plan.

3. INTERVENTIONS

Following the formulation of the care plan, the interventions are implemented.

4. MONITORING AND REASSESSMENT

The person with primary responsibility for the care plan also has a responsibility to update the plan. The final steps in the care process are monitoring progress and reassessment. In a real sense, monitoring and reassessment must occur continuously, because changes in the resident's needs and response to interventions may occur quickly and sometimes unexpectedly. Some interventions, such as medications, may require frequent monitoring to determine therapeutic response levels. Formal reassessment should occur whenever there is a significant change in the resident and also at specified intervals. Provinces vary in their requirements, but more frequent reassessments than those required by provincial standards may be useful, depending upon the needs of the particular resident. The care plan should indicate the monitoring methods, timelines and reassessment intervals for the interventions.

The methods used in the reassessment should parallel those used in the initial assessment, including the team conference. Formal reassessments should also determine if the particular long-term care facility is continuing to meet the resident's needs or whether the resident should be discharged. The reassessment keeps the ongoing cycle of the care process moving ahead.

■ CHAPTER 7

SPECIFIC INTERVENTIONS (TREATMENT AND MANAGEMENT)

INTRODUCTION

Specific interventions aimed at treating the cause of the problem or managing the problem itself must be specified in the care plan after a careful assessment of the problems, their causes, and the strengths of the resident. This chapter discusses briefly some specific medical, psychiatric, and psycho/social/environmental interventions. The next chapter addresses the equally important milieu-programming interventions – including the approach of staff to residents, facility routines and programming, grouping of residents and the physical environment. Conceptually, the distinction between specific interventions and milieu programming is helpful, but in practice the two types of interventions work closely together for the benefit of the resident.

The specific interventions addressed here are those alluded to in the section on the "Search for Causes of the Problems," in the previous chapter.

1. CONSIDERATIONS FOR SPECIFIC INTERVENTIONS

Specific interventions should be selected, implemented and monitored in a manner that is consistent with the principles of caregiving (Chapter 3), with the legal and ethical entitlements of the resident (Chapter 11) and with sound professional practice. This brief discussion cannot substitute for adequate professional consultation and in-service training.

"Treat the treatable" is an important principle for intervention, as is "correct the cause." Using an activity program to deal with withdrawal is not an adequate response when withdrawal is part of a treatable severe depression. Similarly, using a tranquillizer to reduce agitation can be highly inappropriate if the underlying cause (e.g. pain, depression) has not been identified and treated.

An important basis for the success of any specific intervention is a good therapeutic alliance with the resident. Even with residents whose ability to communicate verbally is severely limited or lost, staff can cultivate confidence and a sense of collaboration by attending to the emotional component of non-verbal behaviour (their own and the resident's). It is important that the resident, staff and family be made aware of what is involved in any specific intervention and be supported so that there is appropriate compliance with the therapeutic regime. Side effects of medication must be fully discussed.

"Non-specificity of problems and causes" is another important principle. In many cases, the same problem may have multiple causes (e.g. sleep problems may be caused by depression, pain, fear, putting the resident to bed too early, etc.) and the same cause may produce many problems (e.g. fear may produce aggression, withdrawal, depression, etc.).

With medication interventions, the "rule of thumb" for prescribing is "start low, go slow and monitor frequently," because dosages required for the elderly are very variable and side effects common (Ancil and Mason 1988). However, therapeutic doses should be reached as soon as possible to avoid prolonged resident suffering.

2. MEDICAL INTERVENTIONS

Identifying and treating medical problems that may underlie mental health problems (e.g. infections, dehydration, diabetes, etc.) is an essential part of the care process. For those who cannot report symptoms, it will be necessary to treat expediently. Once identified, such problems can be addressed through sound medical and nursing practice; such interventions need not be discussed here.

The facility staff are frequently involved in the administration of the medical treatments and procedures (medications, nutrition, exercise, etc). Staff (nursing, pharmacy, rehabilitation, etc.) also play key roles in monitoring therapeutic and side effects and making timely reports. Care aides should be trained and supervised by professional staff in the observation and reporting of therapeutic and side effects. Residents who are capable of doing so should also be encouraged to monitor and report the effects of their treatment; this will be of practical help and can foster a sense of collaboration.

3. PSYCHIATRIC INTERVENTIONS

The syndromes where specific psychiatric interventions can be helpful include depressive disorders, delirium, problem behaviour associated with dementias or other disorders, other psychiatric syndromes and adverse drug reactions.

Depressive Disorders

The main biological treatment of depression is antidepressant medication. The diagnosis and prescription should be provided by a physician skilled in working with mental health problems in older people. There are a number of effective antidepressant medications, but they differ in their side effects, some of which can be particularly problematic for the elderly. For example, although younger patients can usually tolerate side effects such as lowered blood pressure upon standing, older residents may well fall and fracture a bone. Drugs which have the fewest such side effects are usually the most appropriate.

Side effects of antidepressant medication which staff should be particularly conscious of include urinary retention, constipation, delirium associated with anticholinergic effects and postural hypotension.

If antidepressant medication at therapeutic dose is not successful in relieving the depression, electroconvulsive therapy (ECT) is considered to be safe and effective (Wasylenki 1980). ECT will usually be administered in an inpatient psychiatric setting or possibly an outpatient setting.

Depression may result from chronic illness. Symptoms related to chronic illness must be investigated thoroughly and treated adequately. Depression often remits when physical conditions are better managed.

Residents with depression may also have anxiety symptoms or psychotic symptoms, and medications are available which may assist in reducing or alleviating these symptoms. It is important that these medications be discontinued as soon as the symptoms are controlled because of the potential for serious side effects.

Once the resident has recovered from the depression, it is usual to continue maintenance medication for up to a year, with continued vigilance for side effects and recurrences of depressive symptoms.

While biological therapy is the mainstay treatment, especially for residents with serious depression, nonbiological treatments are important. These include psychological interventions such as behaviour therapy and cognitive

therapy, supportive counselling, reminiscence therapy, involvement in activities and involvement with family and friends. These treatments/activities may be directly helpful with less severe depressions and may be used as adjuncts to pharmacological treatments. Because research has shown that depression occurs more frequently in newly admitted residents (Parmelee, Katz and Lawton 1989), it is important to make supportive psychotherapy available to residents before and after admission to an LTC facility.

For more information on the treatment and management of depressive disorders, including manic-depressive disorders, see Donnelly (1988); Wasylenki (1987); and Davidson (1989).

Delirium

When delirium presents in the elderly, it should be regarded as a medical emergency (Beattie 1988). The most urgent aspect of care is to protect the resident from harming himself/herself or others and from physical exhaustion. The mainstays of treatment of the acute situation are sedation, hydration and nutrition, nursing care and environmental manipulation. According to Wasylenki, the underlying cause of the delirium (e.g. infection, medication toxicity, etc.) must be diagnosed and treated promptly by the medical staff or the result may be a gradual shift to a stable dementia or death (American Psychiatric Association 1987).

Dementia

There is no specific treatment which will interrupt the deterioration caused by Alzheimer's disease or other progressive dementias. The general principle of intervention is to support quality of life and residual skills; to address the specific problems (e.g. depression, paranoia, sleep problems, aggression, etc.) as they arise, using the best available means (psychiatric treatment, activity programs, modifying the environment, staff approach, etc.); and to decrease the burden on the other residents, family and staff. Approaches to some of the problems in progressive dementias are illustrated below in the section "Interventions for Common Dysfunctional Behaviours."

Adverse Reactions to Medications

As already mentioned, medications are an important specific intervention for depression, anxiety and psychotic symptoms. In addition, they can be helpful in sedation to control symptoms of delirium and to assist in insomnia, persecutory ideas, agitation and aggression associated with the paranoid disorders and dementia (Martin, B.A., pages 149–171 In Wasylenki, *Psychogeriatrics: A Practical Handbook* [1987]). However, older people are especially vulnerable to the adverse effects of drugs because of changed physiological functioning and the frequent presence in the body

of several different drugs which may have adverse interactions (polypharmacy). Staff must therefore be vigilant regarding side effects, and facilities must develop protocols with their medical and pharmacy staff to monitor medication use regularly and carefully. Martin (In Wasylenki 1987) provides useful information on factors in the prescribing, administration and monitoring of psychoactive medications. See also Davidson (1989).

4. ENVIRONMENTAL/SOCIAL INTERVENTIONS

The changes in the environment (social, interpersonal and physical) which can have positive effects on problem behaviours and symptoms are discussed in the next chapter. In choosing the specific environmental/social intervention from those available, a careful assessment of the problems to be addressed is essential. However, there are rarely any "magic answers" or techniques which will work for all residents with the same problem. Indeed, a technique which works for a resident this week may not work next week because of changes in the resident's condition, medications or environment. For this reason, staff must become familiar with a range of approaches and procedures and be open to trying new ideas when old interventions no longer work. Fellow workers, family and literature may provide ideas worth trying. Useful references include Edelson and Lyons 1985; Gwyther 1985; and Fabiano 1984.

5. INTERVENTIONS FOR COMMON DYSFUNCTIONAL BEHAVIOURS

There are no single specific interventions for most of the problem behaviours which concern facility staff, families and residents. To solve the problems, the steps in the care process should be systematically followed: identify the problem, search for causes, intervene and reassess. Here are some suggestions for addressing commonly occurring dysfunctional behaviour, especially in residents with progressive dementing disorders, such as Alzheimer's disease.

5.1 Aggression

Verbal and, in particular, physical aggression can be a serious problem for facility residents and staff. The assessment of the aggressive behaviour should start with an accurate description of the behaviour (not relying on hearsay). Determine when it occurs (e.g.

early morning aggression may be related to depression). Identify precipitants: was it related to an external event such as feeding, bathing, or some other intervention? Is there an underlying physical cause (pain, infection, etc.) or psychiatric condition (delusion, drugs, depression, etc.)? Does the personal/psychiatric history or the current family situation throw any light on the problem?

The management of the aggression should address the underlying causes. In addition, predictable routines, calm, straightforward communication, distraction rather than argument, and attention to emotional communication may help reduce the aggression. Taking into account visual and hearing impairments when approaching a resident can reduce startle reactions and related outbursts. Catastrophic reactions, where the resident appears to be overwhelmed and can "take no more," often include aggression and can be helped by similar methods. Specific non-biological therapies, such as behaviour therapy, can be useful in selected cases.

Where aggression cannot be resolved by treating underlying conditions or by psychosocial and environmental methods, the use of antipsychotic medication with low side effects may be indicated for the elderly. PRN (as needed) administration of these medications should generally be avoided (Ancil and Mason 1988). This type of treatment is often too late and not effective in preventing problems. Martin gives a prescribing protocol for such antipsychotic medications.

Physical restraints to control aggression should be avoided where possible. Experience in several centres suggests that it is almost always possible to avoid the use of the most degrading forms of physical restraints (belts, etc.) with appropriate treatment, facility design, staffing and staff training. However, some form of restraint may be required for the protection of the aggressive resident or others before medication has become effective, or when the resident is being assessed for delirium (i.e. when drugs have been stopped). Physical restraints should be used only as an unusual and temporary measure and should not be applied to replace personal attention or treatment, to punish or negatively reinforce inappropriate behaviours, or for staff convenience. If used, physical restraints should be designed for maximum comfort and safety. The least restrictive form of restraint consistent with safety should be used (e.g. movement to a safe physical space rather than application of restraining belts or similar devices).

The facility must develop policies and procedures on the authorization, application and monitoring of restraints. Ancil and

Mason (1988) discuss in detail the assessment and management of aggression.

5.2 Wandering and Pacing

Residents with dementia may wander from the facility; this can be a major concern. The degree of immediate risk will depend upon the location of the facility and climatic conditions.

Facilities should develop individualized approaches to the resident who wanders, but must also have procedures in place for swift action if a resident does wander from the facility. Medications are usually not helpful in reducing wandering. A few practical suggestions are offered here:

- Provide wandering space outside in a secured area and inside the facility by connecting corridors.
- Remove environmental cues which trigger wandering (e.g. the resident's suitcase).
- Use memory aids meaningful to the resident to help orientation in the facility.
- When residents wander from the facility, follow them, avoid confrontation and gently guide them back.
- Identify wanderers on their charts and with medic-alert type bracelets, indicating the name and address of the resident on the bracelet.
- Install alarms triggered by wanderers approaching an exit.
- Use outings and exercise as programs.
- Inform the local police of wanderers.
- Develop a search plan, especially within the facility, using a two-person approach.

Unlike wandering, pacing is often an indication of agitation; it may be caused by pain, the side effects of medication, or some other treatable cause. Pacing can be a serious problem; for example, residents can pace themselves into exhaustion. Medication may be required to reduce the agitation, but treating the underlying cause is the main priority.

5.3 Sleep Disturbances and Sundowning

Sleep disturbances are a common symptom of depression, especially early morning wakening. With depression-caused sleep disturbances, antidepressant medications, especially those with sedative effects, can be helpful.

Since normal sleep depends upon an intact brain, residents with a dementia frequently have sleep disturbances. They may also manifest the so-called "sundowning" effect, where behavioural disturbances become more frequent towards evening.

The usual environmental impediments to sleep should be reduced. Lengthy daytime naps should be discouraged and facility routines normalized (e.g. by not putting residents to bed early in the evening). Creating fewer demands in the evening (e.g. not bathing if it is stressful) may help sundowning. If these measures fail, and the disturbances are too serious to be accommodated in other ways, medications may be helpful. Wasylenki (1987) offers useful medication suggestions.

5.4 Paranoid Symptoms/Suspiciousness

Suspiciousness or delusions that people are stealing from the resident, or that someone is "out to get him/her," can be part of a distinct psychiatric syndrome (paraphrenia) but are also seen in delirium, depression, schizophrenia and dementia.

While the underlying cause should be treated where possible, Wasylenki considers that "Antipsychotic medication is the most important treatment component for elderly patients suffering from moderate to severe paranoid conditions" (1987, page 102). This includes paranoid features arising from dementias, including delusions and hallucinations. Suggestions for non-medication responses to situations in which residents hide things and then accuse others of taking them include finding the favourite hiding place, agreeing that items are missing and trying to help locate them; reflecting the emotional content but not trying to disprove the false belief; not making fun of suspicious residents' beliefs or discussing them in front of others; and teaching staff to be non-defensive about personal accusations against them (Gwyther 1985). Finally, it should be recognized that apparently "paranoid" ideas may not be psychotic. These may be a material by-product of the diminution of reliable sensory input (vision, hearing, etc.) or of a decline in short-term memory in dementias. Alternatively, the resident may actually be experiencing thefts or abuse, and these possibilities need to be checked out.

There are a number of other common problems involving dysfunctional behaviour (e.g. noisiness, resistance to care, repetitious questions, excessive dependence, etc.). The material presented above is meant to illustrate the importance of adopting a systematic approach to all such problems. In addition, it illustrates the importance of ensuring that staff (both consulting and facility) are skilled in specific interventions, and that they work together in a problem-solving team approach, using specific interventions and milieu programming. The references cited in the suggested readings should provide some useful ideas. Since many of the solutions to these types of problems arise from the specific experience of sensitive staff, it is important for the facility to develop procedures, such as team meetings and in-service sessions, whereby staff can share their insights and together build the facility's "intelligence bank" for solving these problems and providing an improved quality of life for residents with mental health problems.

CHAPTER 8
MILIEU PROGRAMMING

An appropriate milieu is one which supports interaction, socialization and meaningful communication, where residents are allowed to participate in planning as much as they are able and are given choices and flexibility in daily activities. The focus is on the maintenance and enhancement of independence and self-esteem.

The care and treatment of residents with mental health problems in LTC facilities requires an integrated approach which applies principles of care through specific intervention strategies and by establishing an environment or milieu which not only reinforces treatment but enhances and dignifies the quality of residents' lives.

The milieu, in this context, includes, in addition to the physical environment, the staff, the residents, the program of activities and the opportunities available in daily living.

It is a generally accepted premise that the milieu affects the behaviour of all residents and especially those who have functional disabilities. A poor environment can adversely affect a cognitively impaired, depressed or anxious resident's ability to function or interact, resulting in inappropriate or dysfunctional behaviours. On the other hand, an appropriate milieu can provide a supportive framework within which therapeutic interventions can assist in maximizing the residents' potential and improving the quality of their lives.

In an appropriate milieu, the physical environment is structured or modified as much as possible to facilitate orientation in time and space, and to provide a sense of safety and security, comfort and belonging. Staff members interact with residents in a spirit of good will, as friends, therapists and facilitators. Residents' families, visitors, pastoral care workers and volunteers are welcomed and integrated into the milieu. They help residents retain a sense of contact with the broader community and support and encourage active and independent functioning.

Routines and rhythms of the day are major aspects of the milieu that can affect residents either positively or negatively. For example, if meals are scheduled at specific times and there is great pressure to get them finished, many cognitively impaired people who have little which affords them

pleasure except eating, may act out aggressively. Making appropriate changes often does not require additional resources, but it does require support of the administration and senior staff to train and assist care staff in developing and maintaining a humane atmosphere amid the pressures of a facility.

The needs of residents with mental health problems are best met in this type of supportive milieu. The key elements in such a milieu are:

- The availability of sufficient numbers of staff, who by training or experience are able to interact with residents on a flexible, consistent and understanding basis and who are knowledgeable about the disease processes and dynamics influencing resident behaviour.

- A well-developed program of individual and group recreational and therapeutic activities.

- A physical environment which, as much as possible, compensates for deficits experienced by residents, particularly with regard to orientation.

1. STAFF RESOURCES

All staff members must be recognized and involved as part of a team which shares information and knowledge, and all should participate in the decision-making processes that relate to the treatment program. A consistent approach by all staff members is fundamental to the development of an appropriate milieu.

In addition to medical, psychiatric and nursing staff (including aides), the team should have access to specialists/clinicians (either regular staff members or consultants) in the following areas:

- Psychology
- Social Work
- Occupational Therapy
- Activity/Recreation
- Speech-Language Pathology
- Pharmacy
- Dietetics.

All staff members, including support staff (housekeeping, dietary, maintenance), should have education and training in the goals and objectives of the milieu program adopted by the staff and should consistently apply its principles in their interactions with residents. Further discussion of the roles

and expectations of staff members may be found in Ontario Association of Homes for the Aged (1985) and Coons (1981).

2. PROGRAMMING

The approach to programming for residents with mental health problems should be flexible and individualized, and it should be based on a thorough assessment of each individual resident. All team members should be involved in gathering lifestyle information to ensure recognition of residents' needs, interests and abilities. The goals of activity programs should include, but not be limited to, the following:

- improving self-esteem and self-confidence
- fostering communication
- increasing social skills
- developing peer relationships
- decreasing anxiety levels, increasing feeling of security
- developing acceptable habits and skills
- providing opportunities for meaningful contact with other persons and groups and with the community
- maintaining or increasing level of independence in activities of daily living, personal care and grooming.

The following issues should be considered when planning a program of activities:

- All activities should be considered within the context of the physical, sensory, cognitive, emotional and perceptual demands they place on residents. Activities should offer a reasonable chance of success and should be reduced to their simplest components to accommodate limited abilities.

- Programs should be integrated with and support all activities of daily living (e.g. meal preparation and household tasks, baking groups, hygiene and grooming).

- A full range of group and individual activities should be offered. The therapeutic effects of activity programs are maximized when group sizes are small (preferably four to six members).

- Modalities such as music, drama, dance, pets, relaxation, gardening, crafts, exercise, etc. should be integrated into overall programming.

- Programs that are therapeutically oriented should be implemented, when appropriate, by staff well trained in their application, e.g. validation, reminiscence, remotivation, reality orientation.

- Opportunities to participate in off-unit activities and programs should be provided.

- Family support and volunteer activity by family members should be encouraged.

- Involvement of community volunteers in programming, entertainment, and special events should be encouraged.

- Pastoral care and services should be provided and integrated with the activity in the unit.

- Adequate rest and quiet time between activities.

Milieu programming should allow residents to participate in the functioning of the unit as much as they are able. Opportunities for involvement in recreational programs and daily activities should be provided and participation encouraged. Offering residents choices in these activities allows them some measure of control and responsibility and can result in more independence in self-care and improved social functioning. The complexity of the choices offered should be consistent with the particular resident's ability to cope with choices.

Regardless of the specific programming, an overall goal for staff involved in programs for residents with mental health problems is to broaden the individual staff member's perspective of the resident. Too often, nurses and other staff members see residents mainly in terms of their most dependent behaviours, e.g. need for assistance with feeding and bathing. However, if those same staff members see the resident behave in social ways, e.g. enjoying a dance or singalong, that resident becomes more of a person to the staff. Therefore, although programs are conducted primarily for the immediate benefit of the resident, they can also stimulate staff to broaden their perspectives and to share positive experiences with residents.

Residents who have mental health problems may not respond to programs in ways staff might expect. Residents with Alzheimer's disease, for example, may not be able to respond with a smile or verbal expression of enjoyment or to remember any section of the program. However, this lack of "socially expected" reaction does not necessarily mean that the resident with Alzheimer's disease has not been stimulated or has not enjoyed the program. The positive emotional responses experienced may be retained long after the memory of the program itself has faded.

Including direct care staff in the planning and provision of programs enables them to provide ongoing stimulation to residents, for example by raising the resident's activities as a topic for conversation during physical nursing-care tasks. The Ontario Association of Homes for the Aged (1985) and Zgola (1987) provide useful suggestions for programs, especially for the cognitively impaired.

3. GROUPING OF RESIDENTS

Residents of an LTC facility may differ dramatically from one another in terms of physical health status, physical disability or frailty, cognitive functioning, behavioural profile, and emotional adjustment. Ensuring the well-being of such a mixed population within a single facility poses a clinical and administrative challenge. How the challenge is faced determines the effectiveness of therapeutic interventions and the quality of life for the residents.

Grouping of individuals with similar needs is an approach frequently used in health care and other human service institutions in order to meet needs appropriately and effectively. In principle, at least, this approach appears to be consistent with such important concepts as gearing service level to level of need. However, there are pitfalls – conceptual, practical and ethical – that must be avoided if the facility decides to assign residents to different programs and/or separate physical spaces on the basis of clinical and/or functional characteristics.

Often, the grouping of residents becomes an issue when there is a proposal to separate residents with cognitive impairment and/or disturbing behaviours from other residents. Whether or not this is an acceptable option depends on the underlying rationale, the criteria for separation, and the capacity of the proposed arrangements to meet the needs of all the residents involved. It is by no means a clear-cut issue of "integration" versus "segregation," since both terms can describe a wide range of program options, some successful and some seriously flawed.

In practice, the demography of long-term care does not permit "segregation" in any rigorous sense: cognitive impairment and behavioural disturbance are matters of degree, and residents who are affected to some extent by such problems are likely to be the majority in most facilities. Only a fraction of the residents in this group could be accommodated in separate, specialized units or programs. The needs of the less seriously impaired must be addressed by adapting the regular programs and physical environment of the facility.

By the same token, practical and humane considerations rule out a rigorously "integrationist" policy. For example, if a resident's cognitive impairment or problem behaviour creates a safety or health hazard for himself or others, or if the resident manifests special needs that cannot be met within the regular program, it is important to provide a specialized program response. For some, this may include providing an adapted environment that can only be achieved in a separate physical space.

Objections to Grouping

The advantages of grouping can be realized only in well-designed programs, with adequate resources and appropriately trained staff. Poor models of grouping (for example, simple "segregation" of the residents considered most troublesome) are unacceptable on several counts - they may neglect the personal and clinical needs of the individual and create an unhealthy "back ward" environment that is distressing for residents, families and staff. They may promote inappropriate attitudes among staff, e.g. fatalism about resident care, stereotyped responses and a willingness to relegate residents with challenging behaviours to "special care" limbo. A grouping policy that is driven by the rejecting behaviours of residents and staff, rather than by a careful assessment of needs and abilities, is likely to bring together in "special care" a group of individuals with very different needs and major problems of compatibility. If the physical and program environment offered to one group is inferior in relevant ways to that of other groups, separation is difficult to defend from a human rights perspective.

Some have used the principle of "normalization" to argue against any separation of residents. According to this view, mentally impaired residents benefit from interaction with well-oriented residents who can model adaptive behaviours and provide stimulation, support and assistance. It is not clear, however, how many residents with cognitive impairment or disturbing behaviours can benefit from modelling, or to what extent. For persons with severely impaired short-term memory, modelling may be of little value. More to the point, this argument assumes that well-oriented residents are willing and able to provide support and assistance to residents with disturbing behaviours or cognitive impairment. There is some evidence that mixing these populations generates excessive stimulation for some cognitively impaired persons and distress or hostility on the part of some non-impaired residents, leading to confrontations that threaten physical and mental well-being. (See for example Donat 1986.)

"Normalization" remains an essential principle for the care of all residents. Its application may differ, however, for different populations; complete integration of mentally impaired and nonimpaired populations may not be the most "normalizing" option for either group.

Advantages of Grouping

Experience in several Canadian centres suggests that creating separate spaces and programs for cognitively impaired residents with problem behaviours and special needs can reduce major reactions, altercations and other incidents, while improving quality of life, safety and security for all residents. Improvement depends on several factors: clear goals and selection criteria for the separate program; appropriate attitudes, training and numbers of staff; and a physical and program environment adapted to the needs and abilities of the resident.

The reality is that there is no one answer for every situation. Facilities perceive that cognitively impaired residents who have no behavioural problems can be readily integrated with lucid residents, but that those whose behaviour is disruptive and aggressive are better segregated. For some non-lucid residents, it may be sufficient to provide either special programming, individual activities and counselling, or separation at certain times. Others could benefit from secure, self-contained units, with interaction with other residents taking place only in occasional supervised settings.

4. SPECIAL CARE UNITS (SCU)

4.1 Unit

Should the option of a separate, segregated unit be chosen, the following must be clearly defined:

4.1.1 Objectives of the unit – the primary objective must be to improve the quality of life for the residents. Other objectives which reflect this primary orientation could include but not be limited to the following:

- to provide a safe, supportive, low-stress environment for the residents;
- to maximize the physical, social and cognitive potential of the residents;
- to provide staff with the support, education and training required to provide care for this grouping.

4.1.2 Admission criteria – should be based on appropriate assessment and evaluation protocols. Residents who might benefit the most from the special environment are those:

- who are incapable of benefiting from total integration or from the programs associated with it;
- who suffer from over-stimulation or inability to cope with the regular environment of the facility;
- whose cognitive deficits lead to unacceptable territorial behaviour and interaction.

4.1.3 Review process – to determine if individual residents should continue to remain on the unit and to assess the impact of the unit on their functional abilities and quality of life.

4.1.4 Discharge criteria:

- successful resolution of behavioural problems (only if this can be maintained in an integrated setting);
- deterioration in physical condition;
- inability to respond to the special environment and approach;
- persistence of behaviour so disruptive as to compromise the therapeutic milieu of the unit.

The development of an SCU must be based on the firm support and commitment of the administration, board and staff of the facility. Families must be involved in making the decision to place residents in such a unit, and family support and involvement should be ongoing.

4.2 Staffing

The selection of staff for an SCU must be done with care and sensitivity. Staff members should be motivated and express a genuine interest in participating in the special environment created in such a unit. In addition, appropriate knowledge and skill is required to meet the needs of residents in an SCU. If this has not been provided prior to employment on the unit, in-service education must be provided (see Chapter 10).

The traditional assignment of certain functions to a specific department or discipline should be modified if possible. For example, some of the functions of nursing, dietary, activity, and housekeeping aides can be incorporated into one "generic" position, or portions of these various functions can be shared. Such an approach improves consistency of care for the residents, decreases the number of "new faces" residents have to relate to and provides greater variety in tasks while potentially increasing job satisfaction for staff members.

Flexible staffing hours should be considered in order to provide additional staff at difficult times (e.g. evenings, when residents may experience increased agitation, a phenomenon known as "sundowning").

Determining the staffing levels for an SCU is a complex process and is most appropriately undertaken by each individual facility. A facility with improved physical design, for example, may require less supervising time for tracking wanderers, but may have residents requiring higher levels of care than other units and so may require more staff. Surveys have shown wide ranges in the staff hours per resident because of this (Weiner and Reingold 1989). The numbers of "psychosocial" (activity, recreation, occupational therapy) staff relative to nurses should be higher in SCU than in other units because the needs of the residents are primarily psychosocial. Nurses with psychiatric training and experience are often well-suited to work in these units. However, the job classification of the staff is less important than their attitudes and ability to meet the needs of the residents of the SCU.

4.3 Physical Environment

The basic requirement is that the unit be self-contained, with secured doors and low through traffic. The ideal space configuration for the care of these residents is the modular concept with a central focal space surrounded by support and resident-care areas.

A central (or multi-purpose) area is required where communal dining, leisure, recreational and therapeutic activities and programs take place. Single, private rooms opening off the common area best meet needs for privacy, while at the same time encouraging residents to move beyond the confines of their private space. Smaller groupings are advocated because residents with Alzheimer's disease do not function well in large, open spaces. As residents tend to move to the central area where activities become the focus, active involvement or passive participation are more likely to occur.

The general environmental adaptations which are appropriate to elderly long-term residents should be provided in such a unit. These requirements are outlined in Health and Welfare Canada 1984, pages 77–84. There are, however, a number of specific considerations which should be addressed when planning special environments for groupings of cognitively impaired residents.

4.3.1 Size of the unit – is dependent on available facilities; it is not recommended, however, that the unit exceed 30 beds. The ideal size would appear to be 10–15 residents, although this has not yet been substantiated by controlled studies. Staffing considerations may suggest small units be considered sub-units of a larger organizational unit.

4.3.2 Safety and security – the unit should provide a protected environment but allow freedom of movement. A secure outdoor area/courtyard opening directly off the unit is desirable to accommodate the wandering activity of some cognitively impaired residents. Indoor wandering space should also be provided, although the space available is very often limited by size and design. A design without dead-end corridors enables wanderers to keep moving rather than come to a frustrating stop. Nevertheless, some modifications to accommodate wandering are usually possible. Security measures, such as electronic door buzzers, radio wave signal units worn by residents at risk, video monitoring cameras, etc., should be selected to provide for optimal security in the least intrusive manner possible. Masking of doorways and exits with paint or wallpaper is often a simple, effective method for preventing residents from wandering off the unit, but fire regulations must be adhered to.

4.3.3 Exclusion of extraneous stimuli – both visual and auditory. Programming space free of distractions is required for smaller therapeutic groups. Sound levels should be minimized by using materials and textures that absorb sound. Indiscriminate use of TV and radios should be avoided. Intercom systems are not recommended; if used, they should have the capacity to be turned down. "Noisy" patterns on walls, floors, and furniture should be avoided. Extraneous visual stimuli can also be avoided by the use of harmonious, comforting colours. The prevention of glare is of particular importance since glare and reflection can promote disorientation. Glare-free floor covering, screening of large areas of window space, appropriate lighting, and avoidance of white on walls or surfaces all help to reduce glare.

4.3.4 Orientation and memory cues – many examples of orientation aids can be found in the literature. Some examples: use of colour coding on doorways and in hallways, residents' names or other personally meaningful symbols on the walls beside their doors. Personalization of residents' rooms with items of furniture, family pictures and memorabilia should be encouraged (see Ontario Association of Homes for the Aged 1985).

4.3.5 A homelike and comfortable atmosphere should be maintained. Clinical and institutional features should be minimized as much as possible.

CHAPTER 9
SERVICE CAPACITY AND STAFFING

The purpose of this chapter is to assist planners and administrators of LTC systems and facilities to estimate the service capacity requirements for elderly residents with mental health problems. The chapter also covers the issues to be considered in determining the types and numbers of staff needed to address these residents' needs.

1. ESTIMATING SERVICE CAPACITY REQUIREMENTS

There are two types of capacity estimates to be considered:

- how many LTC facility beds are required for this target group in a given catchment area; and,

- for a given facility, with a known number of beds, how many residents are likely to require special services because of mental health needs?

Whether for a catchment area or for a given facility, the service capacity requirements for residents with mental health problems should reflect:

- the epidemiology of mental health problems (number of cases, number of new cases, duration of the problem, etc.) in the catchment area potentially requiring residential care; and

- the type and extent of other available services which can reduce the numbers of people with mental health problems requiring accommodation in an LTC facility. These services include home care and support, day care, respite, mental health community and institutional programs and other formal and informal health and social services.

1.1 Estimating Service Capacity for a Catchment Area

A major factor influencing the need for beds for residents with mental health problems in a catchment area is the age of the population. While the prevalence of some mental health problems does not increase appreciably with age, the problem responsible for the most mental health admissions to facilities – dementia – does. For example, the overall rate for dementia is approximately 1.5 percent for ages 65 to 74, whereas the rate for those over the age of 85 is 27 percent. In addition, very old people are more likely to have concurrent physical limitations and less likely to have informal caregivers. Thus, a catchment area with a relatively high number of people over 85 will have a much greater need for facility care for those with mental health problems than an area with the same percentage of people over 65 but a smaller proportion over 85. Planners, then, need to be sensitive to the present and projected age structure of the population in the catchment area.

Just as it has not been possible to arrive at a completely rational method for determining the number of acute-care hospital beds required by a population in a catchment area, it has not been possible to arrive at a definitive number of beds or services for residents with mental health problems in LTC facilities. Information which can be helpful in estimating requirements includes waiting lists, experience from other jurisdictions, key informant estimates, and estimates derived from the functional status of a representative sample (Forbes et al. 1987).

1.2 Estimating the Need for Services Within an LTC Facility

The nature and number of services required by a facility for the target group will depend upon the numbers and types of mental health problems the residents are referred with and the evolving needs of the residents as they age within the facility. The number of referrals of people with mental health problems is highly dependent upon the availability of other health and social services in the particular catchment area. The age structure of the facility will be significant in that facilities with more very old people will tend to have higher rates of dementia.

The actual number of residents with mental health problems will vary from facility to facility and over time (although the general trend will be upward). However, some indication of the expected

numbers may be gained from epidemiological studies. For example, data translated from the survey of all residents in Alberta LTC facilities can provide illustrative figures for a hypothetical 100-bed facility:

Diagnosis	Beds
Dementia	30
Other Mental Diagnoses	22
Non-Mental Diagnoses	48

Using the same data, the capacity required for the facility to respond to different types of mental health problems can also be estimated. For example, Table VI implies that for the total group, including those who do not have formal mental health diagnoses, the numbers exhibiting problem behaviours in a facility of 100 would be as follows:

Sad, depressed or withdrawn	37
Agitated	26
Aggressive	18

(To extrapolate frequency of other problem behaviours, refer to Table VI.)

Residents with mental diagnoses show a higher rate of problem behaviours, but the rates are still significant for many other residents without such formal diagnoses. Please note that the data provided above are for illustration only; the actual numbers will vary from facility to facility. A resident may, of course, manifest more than one problem behaviour.

Facility management should use the best available methods to estimate the numbers of residents with mental health problems, including both those who do and those who do not have formal mental diagnoses. Staffing and other resources required to meet their needs can then be estimated.

2. ESTIMATING STAFFING REQUIREMENTS

2.1 Principle

A general principle to guide staffing is that there should be sufficient staff with the appropriate training, attitude, specific knowledge and skills to meet the needs of the residents with mental health

problems. Staffing includes both staff employed in the facility and those who come to the facility to provide services.

Generally, staffing ratios need to be higher for residents with mental health problems because of difficulties such as wandering, aggression, lack of daily living skills and associated physical problems.

2.2 Staff Selection

Working with this target group can be demanding, and not all staff are suited for it. Hence, in selecting staff it is often useful to establish a system that will allow staff to choose to work with this group and to move easily to another area if they find themselves not suited to the work.

Management has an important role in selecting appropriate staff for employment and in ongoing staff evaluation. In addition, management should establish guidelines to ensure that staff from outside the facility (e.g. physicians, podiatrists, etc.) have the appropriate skills, attitudes and commitment to the target group.

2.3. Staff Assignment

It is often helpful to residents if the same staff are assigned to them for extended periods of time. Staff should be assigned in the way that best meets, at appropriate times of the day, the needs of residents with mental health problems. Sometimes this will be different from the scheduling of staffing for residents with primarily physical care needs.

2.4. Staffing for Functions

2.4.1 Pre-facility Assessment

The capacity for carrying out assessments which determine if a person should be admitted to the facility should be provided for all those for whom admission is considered a good possibility, and no one should be admitted without a comprehensive pre-admission assessment. These assessments are often done by agencies other than the LTC facility. The staff required are similar to those involved in ongoing assessment, discussed in the next section.

2.4.2 Ongoing Assessment and Care Planning

These services are required for all residents and should preferably be delivered through an interdisciplinary team approach. Staffing includes the physician, pharmacist, nurse, care aide, occupational and other therapists (e.g. speech, physio, etc.), social worker and psychologist and any others required to meet the resident's needs. As often as possible, the resident's family should be included in the team conference. Out-of-facility specialists, including medical (geriatricians, geriatric psychiatrists, etc.) and others (e.g. hearing and vision specialists) will often be used. While it is not possible to provide a standard review period, it is suggested that residents have a team review shortly after admission, another not longer than three months after admission, and thereafter every six months at least, or more frequently if required by the residents' conditions.

The numbers of staff in these various categories required to provide initial and ongoing care planning and review will depend upon the number of residents in the facility and the rate of admission. Where specialists with appropriate training are not available, efforts should be made to train the staff providing the service and to obtain consultative services from outside the facility.

2.4.3 Specific Interventions

The requirements for a particular facility will depend upon the number of residents with problems requiring specific interventions. However, for the medical treatments required, including medication for depression, psychotic symptoms, sleep disturbances, agitation and other problems responsive to medical interventions, medical staff with appropriate knowledge must be available for the initiation of treatment and ongoing monitoring. Where possible, these should be geriatric psychiatrists, geriatricians or general practitioners with geriatric mental health expertise. Since specific non-medication treatments will often be required (e.g. counselling, reality orientation, reminiscence therapy, speech therapy, specialized activity programs, etc.), appropriately trained staff in sufficient quantity should be available to meet the needs of each resident whose intervention plan calls for such therapy (e.g. psychologists, nurses, occupational therapists, and other specialized therapists).

2.4.4 Milieu Interventions

These are programs which apply to numbers of residents and have a general aim of activation, normalization, ongoing personal care (bathing, dressing and other activities of daily living), and the maintenance and improvement of quality of life.

The team involved in day-to-day care will frequently include professional nursing as a core profession. Nurses with specific training or qualifications in psychiatric nursing or geriatric psychiatric nursing are often well-suited to this function. There should be sufficient nursing coverage to meet provincial regulations and to meet the needs of the target group residents.

Care aides will usually provide most of the direct care to the residents in the target group. The importance of effective selection, orientation and in-service training and support for aides cannot be overemphasized. There is no established method for determining the number of aides required for a given number of residents, although some jurisdictions may have minimum requirements. It must be remembered that residents who are ambulatory but have mental health problems often take more care and supervision than do non-ambulatory residents.

Many of the needs of the target group are not narrowly defined physical nursing needs, and nurses and aides need the skills to meet residents' psychosocial needs. Other staff with specific training in activities appropriate for the mental health needs of residents will also be required. These include occupational therapists, other activity therapists (e.g. music, dance, etc.) and aides trained to assist in activation, recreation and activities of daily living. The number of staff in these categories should reflect the residents' needs for recreational activities, social interaction and individual attention on a daily basis.

2.4.5 Staffing of Special Care Units (SCU)

The general discussion (above), about the types of staffing, applies to special units, irrespective of the basis of the grouping. The numbers of staff may not necessarily be greater than for the same number of residents in integrated units. In fact, if the special unit is appropriately designed, staff time previously consumed in preventing people from

wandering off the unit may be redirected to providing improved care. However, often the residents referred to SCU exhibit more problematic behaviour and may therefore require more staff (see Chapter 8, Section 4).

2.4.6 Other Services

Resources to carry out the staff-training function and the monitoring and evaluation service are required. The numbers will depend upon the size and sophistication of the facility staff. Some facilities will have in-house staff to perform these functions, whereas others will have contracts or cooperative arrangements with other agencies to provide or consult on these services.

Residents may require a number of other staff services (e.g. assistance with legal or financial matters). Some of these services may be available through community-based organizations.

2.4.7 Volunteers

Volunteers are a source of companionship, activity and advocacy. Although they are not staff in the sense of being paid employees, they can be very important in maintaining the quality of life of residents with mental health problems (Health and Welfare Canada 1988a and 1984). Initiating, training and maintaining a successful volunteer program to serve the target population is a demanding, long-term task which usually requires the active involvement of a salaried coordinator of volunteers.

CHAPTER 10
EDUCATION AND TRAINING

Excellence in education and training of all personnel is essential if a long-term care facility is to meet the needs of its residents with mental health problems. Since basic education and training of professional and non-professional staff often does not adequately address the needs of this target group, the facility must help its staff develop attitudes, knowledge and skills appropriate to the care of residents with mental health problems. This includes meeting their needs within a homelike atmosphere.

Long-term care facilities operate with a mixed complement of staff, some of whom are employed by the facility while others bring their expertise from outside. The therapeutic milieu provided by the facility is maintained in large part through the efforts of a team composed of a higher-than-average proportion of non-professional staff who are the front-line workers of the establishment. Learning opportunities and training programs must therefore enhance team as well as individual functioning. In this context, designing an education program is challenging and complex.

In addressing the issue of staff training, education and development, administrators of LTC facilities may encounter the following obstacles:

- absence of in-house or local expertise to develop and implement training programs and limited opportunities to develop such expertise;
- limited awareness and knowledge, and inappropriate attitudes among the general population, regarding elderly people with mental health problems;
- difficulties in understanding psychogeriatric problems and developing appropriate problem-solving responses;
- regional differences in the types of service delivery modalities and clientele mix.

1. PROGRAM CONTENT

The content of the staff development program for a particular facility will depend upon the learning needs of the staff. Ideally, staff should have developed excellence in knowledge, skills and attitudes prior to being employed in the facility. However, where this has not occurred, the staff development program should address the deficiencies. Educators can use the list of topics presented in Table VIII as a checklist to help determine the learning needs of professional and support staff. The level of sophistication required in the presentation of each topic depends on the particular job function and individual need. Program content should also address areas of need identified by the staff themselves.

Effective care of residents with mental health problems begins with an understanding of the unique needs and circumstances of each individual. Since working in a long-term care facility is demanding, stressful and carries a heavy load of responsibility, it is important that staff be supplied with the right tools to deal with everyday problems and be given sufficient time to acquire essential skills. Staff members' attitudes toward residents of their facility with mental health problems will influence how they perceive and respond to the needs of the residents. An environment conducive to developing positive attitudes and respect for the residents should be developed. The staff development program should help staff examine their own beliefs, values and attitudes towards dependent and independent elderly adults, while helping to identify the potential for independence of the residents.

2. LTC FACILITY INVOLVEMENT IN EDUCATION

2.1 Basic Training

Basic training (theory and practice) helps health personnel to acquire understanding, knowledge and relevant skills for practice. Continuing, supplementary or advanced education, including field practicum, reinforces and extends this learning.

The basic education of all professionals providing services in LTC facilities should include gerontological and geriatric theory and practice at all levels of health care. Such programs should focus on theories of human development, aging, self-care and health promotion; address the development of disease, disability and social dysfunction; deal with specific treatments and rehabilitation; and give

students clinical experience with elderly persons in community and institutional settings, in both urban and rural areas.

Normally, professionals who have graduated from university and diploma-granting programs possess the education and training necessary to provide excellent care in their respective disciplines. In many instances, however, their preparation will have centred on the provision of service in the acute-care sector, and additional continuing education will be necessary to enable them to adequately address the needs of elderly people with mental health problems.

As is the case for professionals, the basic education of paraprofessionals may require supplementation. In some areas, support staff may have received job-related training from community colleges, vocational programs or junior and senior school options systems. These formal programs should increase the knowledge base of their students by developing modules related to the care of elderly persons with mental health problems.

Long-term care facilities can contribute to improved basic training of professionals and paraprofessionals by making their facilities available for practicum placements and by having their staff participate in such programs. Furthermore, by participating in activities designed to improve public knowledge about and attitudes toward the elderly with mental health problems, long-term care facilities can help attract staff into the field.

2.2 Continuing Education

Most long-term care facilities strive to provide individualized care through the concerted efforts of an interdisciplinary team.

To achieve this objective, management must ensure that the staff is adequately prepared to meet the challenges inherent in the provision of care for residents with mental health problems. This entails developing a continuing education program incorporating appropriate adult-learning principles to encourage the active participation of staff.

2.2.1 Principles of Adult Learning

All adult education programs should incorporate principles of adult learning. In addition, they should consider different modes of presentation and be designed to enhance participation. Programs should be specific to different phases of employment, including orientation and in-service education and training.

TABLE VIII

TOPICS FOR STUDY AND REVIEW

These general topics can be supplemented or modified according to the needs of residents and the learning requirements of staff:

- normal aging and changes in body systems
- normal psychological, social and environmental changes associated with aging
- common psychogeriatric disorders, other mental health problems in the elderly, and problem behaviours
- impact of psychogeriatric illness on the individual and family
- assessment and treatment of mental disorders in the elderly
- comprehensive (physical, psychological) care aspects of progressive dementias
- illness in older adults
- common health problems related to aging
- concept of biopsychosocial process in assessing residents
- concept of milieu de vie
- addressing common problems such as aggression, wandering, depression, etc.
- effects of physical environment
- role of social networks in the health of older adults
- role of staff in health promotion
- role of staff in facilitating family involvement in the care plan and in supporting the family
- role of independence in maintaining self-esteem of the resident with mental health problems
- role of clothing and possessions on self-esteem
- ability of residents to sense caring from staff and families, even when cognitive function has deteriorated
- assessing the strengths of both residents with mental health problems and their families
- detection of physical and mental abuse of the elderly
- team functioning
- management support

Adult in-service education should build on the maturity and life experiences of participating staff. It is important that educators determine the learning needs of participants from a service point of view, assess participants' knowledge bases and identify areas of deficiency in skills, attitudes or understanding of resident needs and behaviour.

The in-service educator should recognize factors conducive to adult learning. These include:

a. active involvement in problem-solving situations similar to the work environment;
b. an informal setting;
c. the opportunity to question and the freedom to disagree;
d. guidance and feedback on individual progress;
e. an environment that promotes mature interactions.

Whenever possible, programs should be developed to accommodate individual learning preferences. Possible presentation strategies include lectures with visual overheads or handouts; seminars or discussions; panel presentations; guest lecturers or consultants; recommended readings; computer-assisted instruction; simulation/role playing; games such as "instant aging"; audio conferences; presentations on a topic combined with guided practice; case presentations and discussions; and program simulation. Availability of resources may determine the method of presentation chosen.

To benefit staff, an education experience must begin at their level of learning and need, emphasize their abilities, use appropriate language for them, involve them throughout the planning and delivery of programs and provide them with incentives.

There are several types of incentives. Some will result in intangible rewards, such as self-actualization and job satisfaction, while others will confer credits, lateral promotions, such as team leadership, new responsibilities on the training team or elsewhere, salary increments or bonuses, recognized expertise and active status within the interdisciplinary team, time off to attend training sessions, etc.

2.2.2 Orientation Program

All staff should be provided, when hired, with a well-developed general orientation program. Such programs should acquaint new employees with their work environment and provide them with a basic knowledge of the needs of the residents and the functioning of the facility. A general orientation schedule could include the following topics:

- the organization chart
- introduction to the facility
- introduction to gerontology
- introduction to principles of care fo. elderly people with mental health problems
- principles of safety related to residents and staff
- discussion of an employee handbook dealing with personnel issues, residents' Bill of Rights, etc.

During the first weeks of employment, each new employee should be paired with another staff member to whom he/she can turn for support.

2.2.3 Orientation Review

A few months after the beginning of employment, all staff should have the opportunity to review the orientation program with the instructor. Their input should be used to supplement and improve the orientation program.

2.2.4 In-Service and External Continuing Education

Following orientation, staff should benefit from a continuing in-service education program. Their professional organizations should offer staff appropriate continuing education opportunities to ensure that they are competent to work with residents with mental health problems. The LTC facility should promote this development where possible.

The facility should be aware of the continuing education needs of all staff and develop an appropriate in-house program addressing both knowledge and practice. Responsibility for the continuing education program should, where possible, be assigned on a full-time basis to a senior staff person with appropriate preparation. In many instances, a nurse will provide the core program, with the assistance of

caregivers from other disciplines, such as a dietitian, occupational therapist, pharmacist or attending physician.

Training and instruction modules can be developed on the basis of the list provided in Table VIII.

2.2.5 Modes of Presentation

A number of different modalities can enhance the continuing education program for a facility. They include the following:

Guest Lecturers

Resource persons from various settings may be invited to discuss common concerns or various topics related to the care of residents with mental health problems. A range of professionals and others involved in direct resident care in other facilities, members of the professional team of the home facility and members of the academic community may be invited to be guest lecturers.

Institution Sharing

Arrangements can be made for staff exchanges between institutions, to promote training and to expose staff to new service modalities. The facility can promote training of its own staff in external settings, as well as provide a training practicum for students in various disciplines or for staff from other facilities.

Resource Centre – Library Services

Where possible, a resource centre located in a designated area readily available to staff could be set up to accommodate a collection of reference materials, articles, books, films, videos, etc.

The service could be developed in consultation with a qualified librarian and be operated by a volunteer. Several facilities in a geographical area can share material to help contain costs.

Case Conference Presentation

The interdisciplinary case review is an ongoing process in many long-term care facilities. Staff may require information about the process and methodology, as well as about the content of case conference presentations. Staff attending should include all members of the team, including the care staff and professionals involved.

This list of examples is by no means exhaustive. A very important aspect of staff development is staff attitude. A positive, open and understanding attitude on the part of the staff will ensure that the residents' needs are identified and that every effort is made to meet those needs. It is important that all staff members attempt to identify each resident's abilities and build upon those strengths. The continuing education program should assist staff in this respect.

Staff development is essential in planning and maintaining a high-quality program for the residents. Although it represents a cost to the LTC facility, it is cost effective if it is well done. As with other programs, it is important to ensure that staff training and education programs are monitored and evaluated for their effectiveness.

CHAPTER 11
LEGAL AND ETHICAL ISSUES

INTRODUCTION

There is increasing attention being given to the legal and ethical aspects of caring for residents with mental health problems in LTC facilities. Staff face legal and ethical issues similar to those encountered by staff in psychiatric hospitals; however, existing legislation often does not address specifically the situation of residents of LTC or other institutions who are incompetent because of cognitive impairment. This causes concern about both the rights and protection of the residents and the legal vulnerability of formal caregivers.

This chapter outlines some key legal and ethical issues and discusses possible responses. It does not purport to offer legal guidance. Given the complexity of these issues and the differences among the provinces and territories in terms of legislation and regulations, facilities must have access to sound legal advice when dealing with particular situations.

1. BASIC QUESTIONS

Most legal and ethical issues arise when a resident with an impaired decision-making capacity is faced with important decisions about personal care or financial matters. Questions that must be addressed include:

- Is the resident competent to make the decision?
- If the resident is competent, has his/her autonomy been respected?
- If the resident is not competent to make the decision, who has the right to decide and on what basis?
- What guidance does current legislation provide?

Other issues concern the adequacy and appropriateness of the services and environment provided to the resident, who usually has little control over these factors. Such issues include:

- Is the facility meeting its ethical, legal and contractual obligations toward the resident and society?

- Is the facility conforming to relevant laws, licensing and accreditation standards, regulations, internal policies, and the ethical guidelines of the disciplines involved in the provision of care?

Related issues concern the management of disturbing or dangerous behaviours manifested by mentally impaired residents. Questions that arise include:

- How can the interests of mentally impaired and unimpaired residents be protected equitably?

- How can the facility balance its responsibility for ensuring safety with that of providing a satisfactory quality of life?

All LTC facilities have the ethical responsibility to implement policies and procedures that will ensure:

a. the protection of residents' rights and human dignity,
b. the timely delivery of appropriate care and services, and
c. the maintenance of a safe and healthy environment.

Ethical responsibility overlaps certain basic legal obligations defined by legislation – including provincial human rights codes and the Canadian Charter of Rights and Freedoms – or by common law. Relevant federal and provincial legislation is discussed briefly in this chapter.

In general, common law places an extremely high value on the mentally competent adult's right to decide what will be done to his/her body and to reject treatments and interventions, even when they may be for the individual's good. In the case of a person who is *not* mentally competent, common law and health care practice have tolerated various measures for decision making on behalf of the person. A common approach has been to identify a substitute decision maker who is expected to use available information to make the decision the way the individual would have made it if he/she were competent (or, if this cannot be determined, the way "a reasonable person" would decide in his/her own best interests).

2. RELEVANT LEGISLATION

2.1 Federal Legislation

Under the Canadian Constitution, the provinces have jurisdiction over the delivery of health and social services,[5] including LTC services. Accordingly, there has been no federal legislation which directly governs these services or provides protective measures or substitute decision-making procedures (trusteeship, guardianship) for persons who are not competent to consent to treatment or to manage their own affairs. (Two minor exceptions concern the administration of Old Age Security payments and veterans' allowances.)

Canadian Charter of Rights and Freedoms

Legislation governing LTC and related matters falls within provincial jurisdiction; however, it is important to note that provincial laws, regulations and practices are themselves subject to the Constitution and, in particular, to the Canadian Charter of Rights and Freedoms.[6] Any law or government action which is seen to be an infringement of rights and freedoms affirmed in the Charter or in human rights legislation may be open to challenge through the courts.

Administrators and service providers share responsibility with other members of the community for working out the practical implications of relevant human rights legislation.

Criminal Code

The Criminal Code[7], which is enacted federally but administered by the provinces, may become relevant in extreme circumstances, if abuse or neglect of a dependent person is alleged.

2.2 Provincial Legislation

In addition to the body of common law that can be drawn upon to address various legal questions, there is specific provincial legislation addressing certain issues. Legislation varies among the provinces and territories, and the process of legislative review and reform is ongoing.

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5 With some exceptions and qualifications that need not concern us here.
6 Sections 7, 12 and 15(1) should be noted in this regard.
7 See Section 197.

2.2.1 Legislation Governing Substitute Decision Making

a. Legislation governing the appointment of a *guardian* (committee, curator) *of the person*: Legislation of this type permits the formal delegation of responsibility to a guardian to ensure that adequate care and protection are provided for a person who is shown to be in need of such services and not competent to provide them for him or herself. Alberta's *Dependent Adult's Act* is at present the only example of comprehensive adult guardianship legislation in Canada.

b. Legislation governing the appointment of a *trustee* (guardian, curator, committee) *of the estate*: All provinces have legislation (Mental Incompetency Act or the equivalent) setting out the process whereby a trustee (either a public agency or a private individual) may be appointed to take responsibility for the management of a mentally incompetent individual's financial affairs to ensure protection of his/her estate.

c. Legislation permitting the donation of an *enduring power of attorney:* Common law permits one mentally competent person to grant a power of attorney to another. Power of attorney authorizes the holder to act in financial matters[8] as the agent of the donor, without diminishing the donor's legal powers. It is assumed that the donor will be able to supervise the person acting as his/her agent; therefore, an ordinary power of attorney terminates automatically if the donor becomes mentally incompetent. However, some provinces have enacted legislation that permits the granting of an "enduring power of attorney," i.e. one which continues to be valid after the donor becomes incompetent.[9] This permits the holder of the power of attorney to continue carrying out financial transactions on behalf of the donor. Concern has been expressed about a lack of monitoring and control of powers of attorney.

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8 A power of attorney cannot, in and of itself, legally authorize the holder to make non-financial decisions (e.g. concerning medical treatment) on behalf of the donor; see, however, footnote number 10 on page 88.

9 Unless the person is declared incompetent by the court as part of a process to establish guardianship or trusteeship.

2.2.2 Adult Protective Legislation

Some provinces have legislation which establishes agencies and procedures for protecting the best interests of adults who are vulnerable because of long-term mental disability or other problems. In some cases, such legislation may have implications for mentally impaired residents in LTC settings.

2.2.3 Nursing Home Statutes (or equivalent)

All provinces have laws governing the establishment and operation of LTC facilities. These laws contain few if any specific provisions concerning the care of elderly persons with mental health problems; however, they define basic minimum standards of care, safety, cleanliness and staffing.

2.2.4 Provincial Human Rights Legislation

All provinces have human rights codes or equivalent legislation typically focused on prohibiting discrimination on various grounds. Such legislation could conceivably come into play if the facility's treatment or management of mentally impaired residents were challenged as discriminatory or otherwise in conflict with the human rights code of the province. (Since the Canadian Human Rights Code applies only to federally regulated agencies, it will have little direct relevance to provincial LTC settings.)

It is important for administrators and health professionals working in LTC settings to familiarize themselves with the pertinent legislation in their own province or territory and to obtain legal counsel when serious issues arise or are anticipated.

3. RESOURCES FOR ADDRESSING LEGAL AND ETHICAL ISSUES

3.1 Legal Counsel

All LTC facilities should have access to a lawyer with knowledge of and experience with the legal aspects of LTC of persons with mental health problems, including consent to treatment, provisions for

guardianship or trusteeship, and issues related to liability for injury or neglect.

3.2 Ethics Committee

An ethics committee with adequate representation of caregiving disciplines, volunteers, administration, residents and family members can help the facility to reflect upon and come to grips with difficult legal and ethical issues. The committee should participate in the development of facility policies and guidelines, provide a forum for discussing particular issues and offer consultation and education to staff and families regarding ethical matters. To be useful, such a committee must meet regularly, include at least some members with training in ethics and use available resources (outside experts, publications, audio-visuals) to deepen the members' own understanding of the issues.

3.3 Community Resources

In anticipating and responding to legal/ethical issues, facilities should call upon expertise available in the community (professional associations, ethics committees of other institutions, academics or clergy with training in bioethics, private consultants, community associations with an interest in health care, aging and human rights, etc.). A facility that remains an integral part of the community, in touch with community standards and values, will more easily avoid legal/ethical problems.

3.4 Residents' Bill of Rights

Some facilities have chosen to adopt and display a formal statement of residents' rights. Such statements are not ordinarily seen as having the force of law. However, courts in some jurisdictions may treat such a statement as a kind of contract between the facility and its clients, an undertaking to provide a certain standard of care. Accordingly, the facility should ensure that the "bill of rights" and the actual guidelines and policies of the facility are mutually consistent. A bill of rights will be of real value only if it is integrated into the orientation and continuing education of staff, and operationalized as part of the ongoing implementation and evaluation of programs.

4. DECISION MAKING

As a general principle, decisions should be made by the person directly concerned, i.e. the resident, provided that he/she is mentally competent to make the specific decision.

Decisions which most often prove legally and ethically problematic are those concerning medical interventions and financial matters. Action taken without the resident's true and informed consent (or in opposition to the resident's valid refusal) can lead to litigation. Physicians have the responsibility to obtain from the resident a valid consent for all medical procedures, and the LTC institution is responsible for obtaining consent for any other intervention (nursing procedures, etc.) that involves possible interference with the person's autonomy or physical integrity, or poses a risk to the person's well-being.

Consent can be given expressly (either orally or in writing), or it may merely be *implied* (i.e. demonstrated actions such as compliance with a request). In matters of routine, non-medical care, the requirement for consent has traditionally received little attention; verbal or implied consent is usually regarded as sufficient for interventions such as dressings, bathing, transferring from bed to chair, and so on. It may be argued that, by accepting admission to an LTC facility and by choosing to continue to reside there, the resident is implying consent to those routine procedures that are considered necessary for care. However, the application of the legal doctrine of implied consent in such cases would depend on several factors (for example, the degree to which the resident is informed about the specific procedures involved in routine care). It is suggested that, at the time of admission, the resident be notified in writing of the care that will be provided, and that written consent to such care be obtained from the resident at that time. Whether consent is written, verbal or implied, its validity depends on meeting the basic requirements listed below. (It should be added that residents who are competent to give consent may also withdraw consent.)

The following are the basic requirements for a legally valid consent for medical treatment; similar requirements are likely to apply where non-medical decisions with serious implications are concerned:

- Consent must be voluntary (without coercion or undue influence);
- There must be full and frank disclosure to the resident of all the information required to make the specific decision;
- The resident must be mentally competent to consent, i.e. must be capable of appreciating the nature and consequences of the proposed intervention

and weighing the factors involved so as to arrive at a reasoned decision;[10] and

- Consent must be directed toward or relate to a specific act or set of acts; a "blanket consent" to unspecified interventions is not adequate.

Often, the most challenging problem is to determine whether the resident is *competent* to make a particular decision and, if not, to make arrangements for substitute decision making.

5. LEVELS OF COMPETENCY FOR DECISION MAKING

It is important to note that, for most residents with reduced cognitive abilities, the ability to make competent decisions is not an "all or nothing" affair. Residents with mental health problems fall into three broad categories in terms of their ability to make informed decisions and to assume responsibility for their actions.

- Those who, even though they may have significant physical or mental impairments, are *fully capable of making informed decisions and understanding the consequences of these decisions:* under Canadian law, adults are presumed to fall into this category unless there is compelling evidence to the contrary (which would normally lead to a medical examination to assess competence).

- Those who are cognitively impaired to such an extent that they are *not competent to make any decisions* regarding their personal care or the management of their affairs (e.g. residents in very advanced stages of dementia): these residents require a legally and ethically acceptable arrangement for substitute decision making about all aspects of care and estate management. Although this group poses certain fundamental ethical problems (e.g. decisions to withhold certain treatments, choice of substitute decision maker, rationale for decisions), the difficulty of defining and delimiting competence is not usually the central issue.

- Those who have diminished cognitive ability and increasing dependence but *who remain competent to make some but not all kinds of decisions* (e.g. consent for routine medical treatment but not decisions regarding management of an estate), *or whose competence fluctuates* as a result of

10 Note that a decision considered "unreasonable" by staff, e.g. refusal of treatment, is not necessarily invalid; competent adults can and do make decisions based on personal priorities and preferences that may appear unreasonable to others.

such factors as the environment, medication reaction, medical problems, or the course of the mental disorder itself: caring for residents in this category involves developing legally and ethically acceptable ways of protecting them from harm and dealing with any problem behaviours. It is important to note that many residents can be capable of competent decision making with extra time and effort on the part of the health care providers.

5.1 Assessment of Competence for Decision Making

All residents who are cognitively impaired to any degree should have a mandatory assessment of competence for decision making before any substitute decision making is undertaken. An initial assessment should be done at the time of admission or shortly thereafter. Arrangements should be made for review of the assessment on a regular basis and, in particular, at the point when consent for any major intervention is required, so as to detect any changes in the resident's decision-making capacity. In the absence of an appropriate examination, residents should be deemed to have the capacity to make their own decisions. Such an approach respects individual autonomy and places the burden of proof on others to show, in any particular case, that the person is incapable of making an informed decision.

The examination for competence must be done by a qualified physician. Although the facility cannot impose the use of a particular approach or instrument on the physician, it should encourage the use of standardized interview procedures and objective measures which address all the relevant areas of decision making. The goal of the examination is to provide a clear statement of the degree and nature of the resident's capacity (or incapacity) for decision making. The report should highlight areas in which substitute decision making is essential, as well as areas in which the resident retains the capacity for autonomy, however limited.

These examinations should be clearly documented, and the reports placed in the resident's file. The appropriate relatives should be advised of this action and, where possible, residents and their families should have the opportunity to discuss with staff the issues of competence and decision making.

5.2 Arrangements for Substitute Decision Making

5.2.1 Financial Affairs

If decisions concerning the mentally incompetent resident's financial affairs are at issue, two avenues for substitute decision making considered legally acceptable are:

- the appointment of a trustee of the estate, under the province's mental incompetency legislation (or equivalent) – financial decisions are then made by the Public Trustee or some other person appointed by the courts; and

- the use of an "enduring power of attorney" where permissible (provided that a properly worded power of attorney was given while the resident was still mentally competent).

The trustee or the holder of the power of attorney should be at "arm's length" from the facility, not a staff member, so as to avoid conflicts of interest.

In practice, minor decisions or transactions with financial implications are often carried out by family members on behalf of the cognitively impaired resident, with or without a power of attorney, and without addressing the issue of competency directly. The risk of litigation is small if the best interests of the resident are clearly being served, if the resident does not object and if staff and families exercise reasonable judgement; however, facilities should be aware that there is no clear basis in law for this kind of "unofficial substitute decision making."

5.2.2 Personal and Medical Care

In provinces where there is no effective legislative provision for guardianship of the person, substitute decision making about personal and medical care of adults is a problematic area in law and medicine. Facilities need to address this issue by establishing clearly defined policies and procedures relating to informed consent, and by obtaining legal advice regarding their implementation.

Most of the cases in which the resident's decision-making capabilities are in doubt can be handled without adverse legal consequences by the LTC facility in cooperation with the next of kin, without formal court intervention.

Routine decisions about personal (non-medical) care need pose no legal difficulty if staff exercise reasonable judgement and courtesy. If the decision involves no significant risk to health or safety, and the resident is able to express a preference, the question of competence need not arise. If the resident cannot express a preference, staff can make such decisions on the resident's behalf, guided by the advice of the family, by previous wishes expressed or demonstrated by the resident and recorded by staff, by relevant policies and regulations and by common sense.

Decisions about personal care take on added ethical importance *if the expressed preference of the resident leads to concern about health or safety* (e.g. the resident consistently refuses to eat, will not bathe, wanders dangerously). If the resident is found to be competent, his/her decision must be respected; if this leads to an untenable situation, and all reasonable options (e.g. normal persuasion, environmental adaptations and behaviour-management approaches) have been explored, discharging the resident may be the only recourse. If, on the other hand, the resident is *not* competent to give or withhold consent, the LTC facility has the responsibility to seek a valid consent from a substitute decision maker.

Medical care includes a range of interventions, some of which are not highly intrusive and involve little or no risk, e.g. physical examination and prescriptions regarding diet or activity. A formal process of seeking substitute consent for every minor intervention would be impracticable. However, the physician should be careful to keep the family informed and seek their input regularly, even for "routine decisions." Moreover, it is advisable and courteous to seek the resident's consent (e.g. for any physical examination), even if the validity of such consent is in doubt. The nurse can often be helpful in working with the physician and family on those issues because of knowledge gained from more frequent contact with the resident and family.

Consent becomes a more pressing issue when the decision concerns more intrusive medical treatments (examples include psychotropic medication, ECT, surgery or intravenous feeding). This is a complex area of law, in which informed consent has traditionally served as a defence against allegations of assault and battery or negligence. The

treating physician is responsible for obtaining valid consent for all procedures.

When the resident is not competent to give or withhold consent, the absence of consent does not relieve the physician or the facility of the responsibility for taking appropriate action to protect the resident's well-being.

It is suggested that the physician's responsibility involves considering the following options, in descending order, with the understanding that application to the court is available at any stage if warranted by circumstances:

a. seeking consent from a guardian of the person, who has already been appointed by the courts (where legislation makes this possible); or

b. seeking consent from a responsive relative who is recognized by the facility and the law as the resident's next of kin, who is known to be competent to make the decision and who understands and accepts this responsibility[11]; or

c. obtaining and documenting the decision of two qualified physicians (preferably including one who is at arm's length from the facility) that the resident is not competent to consent, and that the proposed procedure is necessary for the well-being of the resident; or

d. if time permits and the gravity of the situation warrants, making application to the court for the appointment of a substitute decision maker (where permitted under guardianship or mental incompetency legislation).

Although substitute consent by relatives is an area of uncertainty in law, it is the best practical option short of court intervention and helps to demonstrate that the facility has addressed issues of consent in a reasonable way. It should be noted that a relative's decision about a given intervention

11 Nova Scotia's Medical Consent Act permits a person to use a document similar to a power of attorney to authorize his/her chosen representative to make decisions concerning medical treatment, under specified circumstances. It should be noted that, unless provincial legislation provides otherwise, a *power of attorney*, however worded, does *not* give the holder the legal authority to make medical decisions on behalf of the donor. However, even if such a document has no legal force where medical decisions are concerned, it is usually seen as expressing the donor's confidence in the holder, and it may be regarded as evidence that the donor would choose (or has specifically chosen) the holder as his/her preferred substitute decision maker for medical matters.

should not be accepted unquestioningly by the facility if it appears to conflict with the resident's best interests or previously expressed wishes. In such a case, application to the court may be required.

6. PARTICULAR ISSUES

6.1 Liability for Injury to Residents

Boards of directors/administrators of LTC facilities have the basic legal responsibility for services provided to all residents. They may be held legally and professionally responsible for any situation, which they might reasonably have anticipated and prevented, that causes harm to the resident. Accordingly, the facility must take adequate precautions against all foreseeable hazards associated with wandering, disorientation, aggressive or self-destructive behaviour and other manifestations of mental health problems. In particular, so-called "attractive hazards" should be eliminated.

At the same time, protection from injury is not the only responsibility of the facility, nor is it the only concern of residents and their families. Highly instrusive safety measures may prevent certain kinds of physical injury but may harm the resident's mental health and quality of life. Mentally competent residents must be free to reject intrusive measures and accept a reasonable degree of risk in return for freedom of movement, if they so choose. For those who are not competent to make this choice, the least restrictive measure that provides an assurance of safety should be used. Staff should discuss with families the necessary balance between quality of life and protection from injury. Substitute decision makers may reject certain safety measures for the sake of the overall best interests of the resident. Such decisions, and the process leading up to them, should be documented.

6.2 Use of Restraints/Holding

The use of restraints is an issue of particular significance in the care of residents with mental health problems. Such residents are unable, for the most part, to advocate for themselves, and staff are placed in the unenviable position of being able to exert total power and control. The use of restraints can be distressing and dehumanizing. It deprives residents of the opportunity to achieve their potential level of functioning and enjoy a reasonable quality of life. Restraints can also pose risks for physical health and safety.

Restraints should be used only as an unusual and temporary measure for the resident's protection. They should not be applied to replace personal attention, adequate supervision, programming or treatment, to punish or negatively reinforce inappropriate behaviours, or for staff convenience. Misuse of restraints may be construed as elder abuse and, in jurisdictions with compulsory reporting requirements, would be reportable. However, occasions may arise when the use of restraints is indicated. Criteria for applying restraints must be clearly established by the facility, and their use should be time-limited and carefully monitored. The decision to use restraints should be made on the basis of an evaluation by medical staff, in consultation with the nurse and the family, and the process must be clearly documented in the resident's file.

Restraints may be either mechanical or chemical. A mechanical restraint is any physical appliance that inhibits free physical movement. This includes such measures as tying a resident's wheelchair to a railing to immobilize it, or attaching a lap-top table that prevents the resident from rising. Limiting freedom of movement by installing barricades or locking doors is another form of physical restraint. Chemical restraint is defined as the use of drugs for the specific and sole purpose of inhibiting a behaviour or movement.

6.3 Withholding or Withdrawing Treatment When Death is Imminent

The use of every available medical intervention to postpone death, even when there may be no reasonable prospect of recovery or even survival, has been increasingly challenged and rejected by individuals, families and institutions.

Inventions such as the "living will" (stating the individual's wishes concerning treatment in these circumstances) and the "do not resuscitate" order (physician's order instructing staff to withhold life-prolonging treatment from a particular patient in certain circumstances) are attempts to address this issue in a formal way. Their implications should be discussed with legal counsel.

The patient who is conscious and mentally competent has the right to refuse any medical treatment. A competent decision to reject life-prolonging treatment should be respected even if the individual later loses consciousness.[12] In the case of a mentally incompetent resident, the processes for substitute decision making discussed earlier

12 These principles have occasionally been challenged in court, but are likely to remain fundamental in addressing issues of withdrawing or withholding treatment.

must be followed. Discussing the issue with the family is particularly important. The family should be informed that the appropriateness of an order not to resuscitate is continually evaluated and that it can always be rescinded if prognosis or other factors change. Although so-called "heroic" medical interventions may be rejected, appropriate palliative-care measures must be available.

All communications with the family (or substitute decision maker) and significant others should be recorded. It is recommended that there be a written authorization to withhold or withdraw treatment, signed by the patient (if competent) or by the substitute decision maker, and independently witnessed. The judgements of involved health professionals, and their reasons for a recommendation not to resuscitate, should be fully documented. In addition, there is a need for clear communication among health professionals once an order has been written. Such communication is an institutional responsibility and each LTC facility should have policies and procedures in place for ensuring that all members of the health care team are accurately and promptly informed.

Goals of palliative care include comforting and remaining in contact with the dying resident, relieving terminal symptoms (e.g. pain), providing nourishment and hydration, ensuring skin, bowel and bladder care, and supporting the resident and family through the entire process. Alleviation of suffering is a basic goal of health care; it is part of the care legally and ethically owed by health professionals even when cure is no longer possible.

Finally, it is important to emphasize that mental disability is not in itself grounds for withholding life-prolonging treatment; the mentally incompetent resident has the same right to treatment as other residents.

6.4 Research

Obtaining consent for participation in research raises special difficulties since it may involve exposing subjects to procedures that are not medically necessary. Administrators and health professionals should familiarize themselves with *Guidelines on Research Involving Human Subjects, 1987* (Medical Research Council of Canada). A section of this document discusses research involving mentally incompetent adults, and deals with such issues as the conditions and limits under which these people may be involved in medical research.

6.5 Voting

All Canadian citizens residing in LTC facilities are eligible to vote in federal, provincial and municipal elections, even if they have a mental disability,[13] unless they are deemed ineligible by the returning officer at the polling station. If a resident appears incapable of understanding the nature of this action, the returning officer may question him/her and has the discretion to prevent the resident from voting. Administrators should make it as easy and non-stressful as possible for all eligible residents to vote. Residents with communication problems or other impairments, who are otherwise able to vote, may need to be accompanied to the polling station to avoid any misunderstandings concerning eligibility.

13 Some restrictions are applied in certain provinces.

■ CHAPTER 12

PROGRAM MONITORING, EVALUATION AND RESEARCH

Monitoring and evaluation are integral parts of optimal program management and important aspects of quality assurance.

Monitoring is a means of providing periodic feedback. It makes available up-to-date information on any aspects of the program which are deemed important: the changing clientele profile, the quality of care provided by various members of the interdisciplinary team, and staff training, to name a few. Monitoring is an ongoing process which permits a comparison of the actual services provided with those desired at the outset, so that adjustments can be made if necessary. It requires agreement on attributes to be measured and the desirable criteria to be met.

Evaluation provides information on program performance: to what extent have targeted goals and objectives been attained? What are the strengths and weaknesses of the program? What improvements can be made?

Ideally, monitoring and evaluation should be initiated at the conceptual and developmental stages of any program. If this has not been done, monitoring and evaluation should, nonetheless, be incorporated as soon as possible. This is essential for two reasons: (1) the field of long-term care for residents with mental health problems is a relatively new one; all answers are not yet available, and administrators have to remain open to the idea of frequent readjustments in program organization; (2) since the target population, by its very nature, may have difficulty conveying its needs and its dissatisfaction, it becomes the responsibility of the facility to ensure that these are evaluated objectively.

For example, if a segregated unit is developed in a facility, systematic evaluation of its functioning must be done to ensure that it is not becoming a "dumping ground." A quality evaluation question might be whether residents who are capable of integration for some activities are in fact being integrated.

1. DEVELOPING APPROPRIATE MEASURES

Few instruments are available as yet for the measurement of quality issues related to LTC of such residents. This should be viewed as a challenge and an incentive to develop the necessary tools. Involvement of the inter-disciplinary team or other clinicians in developing approaches to quality assurance has obvious advantages: assuring the relevance of the instrument for the target population, increasing staff involvement and motivation, and reducing staff resistance to program changes arising from evaluation. The collaboration of clinicians and administrators in the development of approaches to quality assurance should ensure that issues of both effectiveness and efficiency are addressed. It is important to avoid a simplistic use of criteria in defining objectives. For example, an exclusive preoccupation with reducing the patient fall rate to zero may result in residents being continuously restrained or medicated in order to prevent any chance of falling.

2. ANALYSIS AND FEEDBACK

Staff should also be involved with management in the analysis of information from monitoring and evaluation processes. For example, monthly reports on such items as use of restraints, drug use, incidents of aggression, patient incontinence and so on should be reviewed by management and care staff. Findings and recommendations should be discussed with staff on the unit in order to provide them with feedback, to allow opportunities for their input and to clarify the significance and practical relevance of the continued monitoring of the items in question.

Data should not be collected if they cannot be used. On the other hand, useful data should be collected by the most relevant member of the team. For instance, aides have an essential role in this process; if they are not permitted access to medical charts, they should be provided with other means of recording.

3. STRUCTURE, PROCESS AND OUTCOME DATA

The following non-exhaustive lists give examples of typical items which could be monitored and evaluated in a program of long-term care for residents with mental health problems. The decision as to what data to

collect should hinge upon what program decisions will be affected by it. The team member concerned with the data should be involved in their collection.

3.1 Structure (Are the necessary resources in place?)

Service system environment:

- factors which have an impact on the program, such as alternative or complementary facilities in the sector;
- mission of the facility and its relevance to the program;
- demographic changes in the catchment area;
- nature of external pressures to admit residents.

Clientele:

- sociodemographic profile;
- functional level, nursing hours required, types of pathology, mental status, problem behaviours, medication, social and family needs;
- items pertinent to other clientele, such as families or students (in the case of a teaching facility).

Resources (human, material and financial):

- staffing levels, nature and numbers of interdisciplinary team members, staff training;
- characteristics of the physical plant (design, space configuration);
- nature, condition and location of available equipment and software;
- size and allocation of budget.

Organization:

- policies and procedures (manual): existence, relevance for long-term residents with mental health problems, regular updating;
- committees and team structures;
- organization structure (reporting);
- statements of residents' rights, obtaining residents' consents, respect-of-confidentiality issues, updating of assessments for decision-making competence, updating of committeeship/guardianship arrangements, safekeeping of assets.

3.2 Process (Are the necessary procedures being carried out?)

Process audit:

- compliance with policies and procedures, including patient care planning;
- compliance with clinical practice guidelines and professional standards;
- compliance by staff and patients with policies, procedures, protocols and treatment plans.

Measures:

- incident (rates) reviews;
- patient care audits;
- mortality rate (or discharge condition rate);
- levels of care required;
- resident turnover;
- staff turnover;
- patient compliance rates;
- drug error rates.

3.3 Outcome (Are the desired results being achieved?)

- resident turnover, staff turnover, resident transfers, autopsy rate and concordance with clinical diagnosis;
- residents' participation in activities, maintenance of functional abilities;
- intervention analysis: management of aggressive and disruptive behaviour, approaches to the grouping of residents, palliative care, treatment of medical and psychiatric illness, rehabilitation measures, volunteer satisfaction.

Outcome measures should address the essential long-term goals of patient management in the units concerned. Assuming that each patient has had a treatment goal defined, outcome evaluation would address the degree of success with which the unit has achieved the collective goals of its patients. Secondary measures of outcome would address proportions of patients transferred or discharged and their conditions upon discharge. Satisfaction surveys may also be considered, but care is needed to ensure that they are relevant to the goals of the organization. They are helpful but generally not sufficient as a measure of unit effectiveness.

Engaging in such processes as the accreditation of the Canadian Council on Health Facilities Accreditation can be helpful to facilities in their monitoring, evaluation and quality assurance responsibilities.

4. RESEARCH

The field of long-term facility care for residents with mental health problems is a relatively new one. There is a considerable need for research to augment and integrate our knowledge base in this area in order to improve services for the target population. LTC facilities can cooperate in the research effort.

A variety of issues and aspects of care could profit from systematic study. Examples include comparisons among different models of segregation and integration of residents, private versus shared rooms, impact of staff changes and rotations, family visits to facilities, staff training, measures to improve staff morale, medication trials or trials of different types of intervention (psychotherapy, behavioural management, environmental adaptations to decrease wandering, and so on).

As in any other type of facility, administrators must ensure that the appropriate ethics committees exist to study and approve all research protocols and to safeguard the rights of incompetent or otherwise vulnerable residents. A facility that lacks these resources should consider inviting help from credible institutions, such as universities or research bodies in other hospitals.

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APPENDIX A

LIST OF GUIDELINES FOR INSTITUTIONAL PROGRAMS

The following guidelines have been prepared by the Federal/Provincial/Territorial Subcommittee on Institutional Program Guidelines. These guidelines were requested by the Federal/Provincial/Territorial Advisory Committee on Institutional and Medical Services. Some of the guidelines are updated versions of guidelines previously published by the Subcommittee.

Addiction Services in Hospitals (1984)
Adult Long Term Institutional Care (1984)
Adult Psychiatric Services Provided by General Hospitals (1989)
Assessment and Placement for Adult Long-Term Care: A Single-entry Model (1988)
Breast Imaging Services: Mammography (1986)
Burn Unit (1985)
Cardiovascular Services in Hospitals (1986)
Child and Adolescent Psychiatric Services Provided by General Hospitals (1980)
Child and Adolescent Services in General Hospitals (1982)
Child and Youth Long Term Services (1985)
Chronic-Pain Programs (1990)
Computed Tomography (1986)
Day Surgery Unit (1982)
Dental Care Units in Hospitals (1979, under revision)
Diabetes Services (1989)
Diagnostic Imaging Services and Systems: An Overview (1986)
Diagnostic Ultrasound Facilities in Hospitals (1985)
Emergency Services in Hospitals (1989)
End-Stage Renal Disease Program (1986)
Geriatric Services in Acute-Care Hospitals: A: Geriatric Assessment and Treatment Units B: Geriatric Day Hospitals (1990)
Health Care Related to Abuse, Assault, Neglect and Family Violence (1990)
Hospital Day Medicine Unit (1984)
Intensive Care Services (1986)
Magnetic Resonance Imaging (1986)
Nuclear Medicine Units in Hospitals (1985)

Organ and Tissue Donation Services in Hospitals (1986)
Palliative Care Services (1989)
Patient Hostel Unit (1978)
Perinatal Intensive Care Units in a Perinatal Care Network (1986)
Pre-Hospital Emergency Care Services (1985)
Pulmonary Function Laboratories (1982)
Rehabilitation Medicine Program (1986)
Respiratory Therapy Service (1987)
Services to Elderly Residents with Mental Health Problems in Long-Term Care Facilities (1990)
Spinal Cord Injury Program (1986)
Stroke Program (1986)
The Reuse of Disposables: An Information Report (1985)
Vital Organ Transplant Centres (1986)